THE UNIVERSITY *of* EDINBURGH

“This Is My Life Now”: Lived Experiences of Residents in Care Homes in Goa, India

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Doctor of Philosophy

The University of Edinburgh

2013

Declaration

I declare that this thesis is originally composed by me. It is based on my own work, with acknowledgements of other sources, and has not been submitted in whole or part for any other degree or professional qualification.

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September 2013

Abstract

Increasingly, old people in India are moving into institutional settings. There is a paucity of qualitative research examining the condition of residents in care homes. This thesis addresses this gap through a detailed qualitative study of three such homes in Goa, India. It explores the care processes and practices in the care homes and how far they are attuned to the needs, lives and identities of their residents. An understanding of the experiences of residents as they have been undergoing different stages of entering and settling into a residential care setting has been the main focus of the research, which illuminates the context in which resident experiences were embedded.

The thesis explores the process of institutional living: the conditions (losses and changes) that lead older people to enter institutional care; the losses and changes incurred while entering institutional care; the paradox between induced dependencies created by institutional control and structures resulting in passive compliance; and the struggles of the residents to resist these power structures. In documenting life for the resident in the care homes the thesis shows that their subtle daily forms of resistance exist within a framework of power. The final empirical chapter discusses how residents experience different forms of departure, whether as ending this struggle or beginning a new one.

Data were collected through a combined ethnographic methodology of participant observation and semi-structured interviews with residents, staff and management over an eight-month period, in addition to a scoping survey of 37 care homes in the State. The study retrospectively examines residents' experiences during various stages – pre-entry, entry, post-entry and exit – of their residential career, the drivers and constraints during these stages, and the role of staff and management in contributing to these experiences. These are presented as narratives – interleaved stories highlighting (some) important aspects of life in care homes in Goa. I have included the various responses made by residents to the different stages of their residential career – their ambivalences as well as their certainties, their anger as well as their passive acceptance, their dependence as well as their agency – and to

interpret residents as sometimes vulnerable, sometimes invincible, and sometimes struggling. In doing so, I have provided insights into the ups and downs of life in care homes in Goa, through exploring paradigms that were crucial to residents' lives in my study.

These insights reveal that the dismantling of residents' individual autonomy and control occurred prior to their coming into the institution. Once inside the care home, their lives were further altered by rules, routines and practices of staff and management. The resident's identities thus were increasingly being defined by the institution. The findings further revealed that residents do not always accept passive dependency but instead struggle to carve their own identity within the institutional settings and controls they are subjected to. Finally, my findings reveal how perceptions and preparations for departure from the institution are coping mechanisms used by the residents and the staff alike, as extensions of their struggle for survival, freedom, and control.

These findings lead to a greater understanding of how different processes are intertwined in residential careers for residents in care homes in Goa. The findings invite a rethinking of conceptions of autonomy and ageing, passive compliance and agency, and departure and coping, particularly within the context of institutional living in Goa. This study has thus illustrated the mechanisms in place for older people entering, settling and leaving care homes in Goa and demonstrated whether these mechanisms are adequately suited to their needs. The hope is that this understanding will contribute to the development of improved policy and practice that better reflects the needs and wellbeing of older people.

Dedication

This work is dedicated to my loving parents Domingos and Bertilda Menezes for their endless support and encouragement throughout my academic journey.

Two roads diverged in a wood, and I,
I took the one less travelled by,
And that has made all the difference.

Robert Frost

Acknowledgment

I have been dreaming of this day for a long time. Now that it is here, there are many people I need to thank.

First, I like to thank my supervisors, Dr. George Palattiyil and Professor Roger Jeffery. You have contributed in so many ways to this final product – not just the thesis, but also the student. I really appreciate your input into my education. I also need to thank my examiners, Professor Eric Blyth and Dr Jeevan Sharma. You have exposed me to new and different ideas and pushed me to think deeper and more critically. I hope this is not the end of our collaboration.

Thank you Prof. Charlie Jeffery, Prof. Fiona Mackay, Prof. Viviene Cree, Prof. Patricia Jeffery, Prof. Crispin Bates, Prof. Susan Hunter, Prof. Bill Whyte, Dr. Janice McGhee, Dr. Gary Clapton, Dr. Ruth Forbes, Dr. Alison Koslowski, Dr. Ingela Naumann, Dr. Wilfred de Souza, Dr. Dina Sidhva, Dr. Jennifer Speirs, Dr. Sweta Srivatava, Dr. Aditya Bharadwaj, Ms. Engelina Davids and Fr. Lucas Chang. I am immensely grateful for the immeasurable support – academic stimulation and guidance – you have provided during the last three years. To everyone in the Social Work Department and the Graduate School of Social and Political Science at the University of Edinburgh – staff and colleagues – I have enjoyed my last three years with you. I cannot speak highly enough of the department, the School and all of you.

I am eternally grateful to the British Council de Souza Trust Scholarship and the Government of Goa Scholars Fund whose sponsorship brought me to Edinburgh and opened many doors of opportunities. I thank the Department of Social Work, Edinburgh University for the Mclean Legacy Grant, School of Social and Political Science, Edinburgh University for the School Scholarship, College of Humanities and Social Sciences, Edinburgh University for the Gray Scholarship and Edinburgh University Centre for South Asian Studies Scholarship Fund. I also thank the Dominican Friars at the Catholic Chaplaincy, University of Edinburgh – Farther Tim and Fr. Dermont, the Sisters of Mercy, Edinburgh – Sister Aelred, Sr. Dominic, Sr. Catherine and the other Sisters in the community and the Missionaries of Charity, Edinburgh, for providing various levels of support – psychological, spiritual and financial – for the successful completion of my studies. Many thanks to the

Edinburgh India Institute and Academy of Governance at the University of Edinburgh for providing me with a job when I needed it most.

My parents Domingos and Bertilda Menezes – thank you for your encouragement and for making me into the person that I am. For all my successes you deserve credit. Your constant support, understanding, warmth, love and prayers have helped to give me the cheer and encouragement I needed while writing my thesis. Thank you. I would not be here without you. Thank you also to my brothers, Danzyl and Brazyl Menezes for believing in me and pushing me to strive high. Thank you to the latest additions to our family – Margarida, Reena, baby Braelyn and baby Keziah, – you came into my life and filled it with joy and happiness. Thank you Arnab, you will never know how much I appreciate your patience, love and support since you came into my life. Thank you for affirming me time and again during various phases of my PhD.

I owe a debt of gratitude to my comrades in Edinburgh – Supurna Banerjee, Vinnarasan Aruldoss, Feyza Bhatti, Anindya and Clare Raychaudhuri, Eva Gallova, Angelina Mattijo-Bazuba, Jaqueline Heron, Oliver Rodil, Louchelle Zurita and Francine Chidi for accompanying me in this journey. I would also like to thank my numerous friends and well wishers who have been supportive and shown considerable concern and interest in my life. Of special mention is Jean Faulkner, Lindsay Adams, Rosemary Okoli, John Morgan, Liz Gallagar, Lyndon Monteiro and Franco Fernando – thank you for your emotional and personal support.

I am grateful to all the people who participated in this research. Thank you to the staff and management of all the care homes I visited and studied for making me feel welcome and for supporting the research. You have become more than participants, have become friends. And most importantly, thank you to the residents who participated in this research. You have opened the window to your lives and let me have a glimpse in. Thank you so much. I have learned more from talking and spending time with you than I have in the past. Thank you for sharing your wisdom. You have been amazing teachers. I hope I have been a worthy student. Also to the staff of HelpAge India, Goa Office I say a very big thank you for providing useful information and insights during my fieldwork.

I thank all who contributed to the success of this work and whose names have not been specifically mentioned because of space constraint but I assure you that I very much value and appreciate your support.

My immense thanks to the Almighty for being my constant support and guide throughout my life.

BLESSED are they that respect my lame leg and my paralysed hand

BLESSED are they who understand how much effort my ear makes to hear what they say

BLESSED are they who do seem to realise that my eyesight is misty and that my thoughts travel slowly nowadays

BLESSED are they who do not only spare time to chat to me, but smile as they do so

BLESSED are those who never say: 'You have told me that story before!'

BLESSED are they who know how to call up my memories of days gone by

BLESSED are they who bring back to my mind that I have been loved and esteemed in the past, and that I am not rejected even today

BLESSED are they who through acts of kindness make easier the days which separate me from the day of my arrival in the Realm of Eternity

THE LORD WILL REMEMBER THESE BLESSED ONES

(The Beatitudes according to the aged translated from a leaflet found in Brussels Cathedral, 1975)

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Abbreviations and Acronyms

UN: United Nations

WHO: World Health Organisation

RIW: Research Institute for Women

UK: United Kingdom

USA: United States of America

PICA: Parents in India, Children Abroad

NGO: Non-Governmental Organisation

MIPAA: Madrid International Plan of Action on Ageing

IFSW: International Federation of Social Workers

UNPA: United Nations Population Fund

Chapter 1: Introduction

> *"Why are you researching these people (older people in care homes)? They have no future, hence, your research will not be able to do much…you should study children in orphanages or something." (Rahul, Assistant Manager, Government home)*

The lives and experiences of older people in care homes remain marginalised not only within academic research but also in everyday interactions. Given this marginalisation and apathetic attitudes as reflected in the above account, how do residents in care homes experience everyday life? How do they retain their identities? This research aims to explore these questions by using field-notes and interviews conducted with 24 residents, 12 staff and 4 managers in three care homes in Goa. Through this analysis, I will explore the specific aspects of residents' experiences within a theoretical framework of institutional living, and draw out implications from data collected from the field: pre-entry, entry, post-entry, and exit, bearing in mind the different stages of older people's entry and adjustment in care homes. The study invites older people's voices to be heard within the institutional care discourse.

1.1. Rationale

My primary motivation for this study is multifaceted. Firstly, the research builds on my personal interest and past experience as a volunteer in care homes in Goa. During this time as a volunteer, I became aware of the issues involved, including staff workloads, lack of time, lack of training, demanding regulations, lack of staff support, uncaring attitudes, and sometimes unsupportive management. I witnessed many incidents where residents were treated poorly. I saw the emotional distress and trauma that many residents experienced and felt helpless to ease or comfort them. These personal experiences have had a profound impact on me as a person and as a researcher. They have influenced how I think about care homes and have fuelled my commitment to improving the quality of life of residents living in these settings.

Secondly, the focus of my undergraduate and postgraduate theses has been on how devalued and stigmatised members of society create spaces of power and freedom in their everyday lives. My undergraduate report showcased Judicial Activism and Public Interest Litigations as mechanisms of empowerment for citizens lacking a formal agency to represent them. My postgraduate dissertation researched citizens' report cards, which service users used to grade government services and assert their rights. Post this, I prepared a manuscript on the lives of eight women who chose male dominated professions, including cobbler, bus conductor, petrol pump assistant and a bike pilot among others. The experience of writing these three pieces motivated me to use the same form for documenting my voluntary work with older people who I saw as stigmatised, devalued and lacking a voice. Furthermore, my voluntary work with vulnerable people, some of whom were stigmatised because of their choices or circumstances, further prompted me to explore whether stigmatised and devalued individuals resist their predicament in their everyday lives. This study is the result of this motivation and interest.

Finally, what encouraged me to undertake this research was the need to understand the perceptions and experiences of care home residents who are often made invisible in care policy discourses in India. I wanted to know more about their lives. How and why do they enter care homes? Is their entry and adjustment difficult? Do the homes help to negotiate this change in their circumstances? How do the residents relate to each other in a communal environment? How are their lives shaped in the midst of institutional controls and power dynamics operating within care homes? How do they see their future? These questions are at the heart of this thesis. It is my hope that this study will contribute to providing much needed information on older people in care homes in India, particularly from their perspectives, and to policy development for older people and care homes in the country.

1.2. Brief general overview: Global and local

Although I will discuss ageing and institutional care globally and locally (India and Goa) at length in the next chapter, I will provide a brief overview in this section. From the start, however, it is important to define 'older person' and 'care home' as used in this study. The Ministry of Social Justice and Empowerment, India,

defines an older person "as anyone above 60 years of age" (Ministry of Social Justice and Empowerment, 2007: 1.1-1.2). Furthermore, Indian censuses and scholarly works from which I have generated a large amount of my demographic data have also used 60 as a cut-off point for classification of the older population. Finally, entry to a care home in Goa – which is the field site of my study – also requires older people to be 60 years old or above. Thus, for the purpose of this study, I have used 60 years and above as a guideline for referring to an individual as an 'older person'. The term 'care home' refers to all residential long-term care settings which provide personal and/or nursing care for older people. It has been used synonymously with institutional care and residential care for older people in this thesis.

The importance of institutional care for older people all over the world is realised at the juncture of two major societal developments: the ageing of the population and the increasing number of older people looking for options for alternative care arrangements in the absence of home-based care. The ageing of the world's population is reflected in population statistics. According to the United Nations (2009) the number of older people in the world will increase from 737 million in 2010 to 2 billion in 2050 (United Nations, 2009). Although in 1990 the number of children below 15 years was estimated to be 3.3 times higher than people aged 60 and above, older people are expected to surpass the number of children by 2050 (Rajan *et al.*, 2003:13). A clear majority (62%) of the world's older population live in developing countries, with India and China sharing the major proportion (Patel and Prince, 2001). According to Indian 2011 census figures, there were 12.1 million people in the 60 and above age group in 1901. This number increased to 24.7 million in 1961, and thereafter increased each decade to 77 million in 2001 and crossed the 100 million mark in 2011 census (Government of India, 2011). This figure, which is 8.6% of the country's total population of 1.23 billion is expected to rise to 21%, 323 million, by 2050 (Government of India, 2011; Bhat and Druvarajan, 2001). According to the 2011 census, the proportion of people aged 60 years and above in Goa lay at 10% above the all-India figure of 8.6% (Government of India, 2011).

This demographic change is accompanied by socio-economic developments such as globalisation, liberalisation, urbanisation and migration. These changes are

undermining the capacity of families to provide support to older people as well as the traditional norms underlying such support (Kumar, 1997). This development has resulted in older people looking for alternative care arrangements. The result is that the majority of the older people who are in need of alternative care arrangements turn to institutional care because either they cannot afford commercialised care within their own homes or there is a lack of these alternatives in their locality (Bhat and Druvarajan, 2001). The consequence has been a mushrooming of institutional care – care homes – for older people (Peace *et al*., 2007; Hughman 1994; Jones and Fowles, 1984; Townsend 1981). The question is, how are these large number of older people cared for in care homes, and more importantly, how does this affect their quality of life and the opportunity to live with dignity and independence in these settings (Coons and Mace, 1996)? This includes the importance of enabling older people to continue in normal social roles that provided meaning and stability in their earlier lives (Cumming and Cumming, 1962).

'Graceful ageing', 'active ageing', 'person-centred care' of older people are concepts proposed by the United Nations to allow older persons the ability to optimise their potential for independence, good health and productivity while providing them with adequate protection by and care from the family, the community and the state (Chakraborti 2004). United Nations Principles for Older Persons (1991), the Ageing and Health Programme of the World Health Organisation (1999), the Madrid International Plan of Action on Ageing (2002), International Policy on Ageing and Older Persons (2009) and subsequent international research and policy efforts show that a consensus is emerging among international policy makers concerning the provision of institutional care for older persons in need. This emphasises the role that institutional care plays in the continuing development of older people. Thus the need for institutional care and its ability to enable or inhibit the autonomy and identity of older persons is emerging as an urgent and pressing issue. This warrants a deeper study as well as the development of newer and deeper insights into the issues related to institutional care in developing countries where such studies are limited.

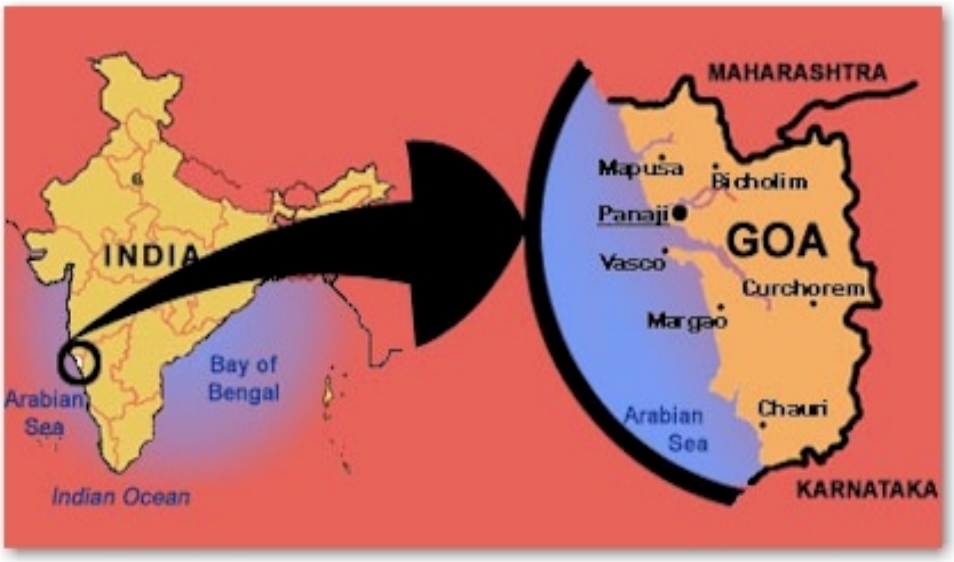
It is from the 1950s onwards that long term institutional care has been reflected in intellectual debate in the international sphere. Eminent researchers such

as Barton (1959), Goffman (1961), Foucault (1967) and Szasz (1961) pointed out the role of institutions in society and the impact that they have on their residents. While Foucault and Szasz conceptualised institutions as places of repression and social control, Barton and Goffman focussed on the individual resident's experience of incarceration and examined the process of depersonalisation of the resident's self which takes place within an institution. The theoretical paradigm of institutional care in this research relates to institutional care of older people. Although the institutional care for older people has attracted a wide ranging literature on residential institutions in the West, particularly in the 1970s and 1980s, India has not so far shared in this burgeoning of interest. There are obvious reasons for this neglect. Currently in India, the preference is for elder care to be provided within the family setting. Cultural concepts of care and joint family structures have constructed this care as critical to family functioning and family cohesion (Brijnath, 2012). Such cultural practices are augmented by a legal environment which seeks to place the primary responsibility of care on families and to both reward and penalise families when they do or do not fulfil these responsibilities. A notable example is the Senior Citizens Act 2007, which gives tax relief to families who care for older relatives but applies penalties, including fines and a maximum prison sentence of three months, to those families who avoid their responsibilities (Ministry of Social Justice and Empowerment, 2007). This is supported by policy makers and opinion formers who have an ideological hostility to admitting the potential limitations of the family in caring for older people (Brijnath, 2012). Most of the primary surveys conducted among members of the older population clearly indicate a preference among respondents to stay either with their children or with their own family members (Nanda *et al*. 1987; Brijnath, 2012). Within such contexts, care homes are viewed with deep ambivalence and stigma is attached to older people entering these homes. The source of this stigma is considered to lie in the "violation of traditional cultural norms" where older people are cared by their children (Blyth and Moore, 2001:218).

As indicated, with economic development, migration, urbanisation and the resulting changing family structures, the care arrangements and the preference for home-based care for older people is changing in India. As a result, care facilities for the aged are rapidly increasing and the Indian government has taken steps through

policy and legislation to define its role in elder care as an auxiliary, not primary, source of support. HelpAge India (2009) estimates that there are 1014 care homes in India. Alongside this, Government organisations, Non-Governmental Organisations and civil society in India are debating whether this growth should be allowed, supported or curbed. There is a strong feeling among some policy makers and civil society groups that proliferation of care homes would make it easier for children to avoid their responsibility for taking care of their ageing parents by placing them in these homes (Brijnath, 2008). Their argument is that increasing institutionalisation of older people would lead to erosion of traditional family values and might even lead to a break-up of the institution of the family itself. However, while this is a possibility in view of the decline in traditional filial obligations among children and the lack of an adequate social security safety net, there is arguably a need for care homes to accommodate the increasing number of older people who are lacking the traditional means of familial care. However, if well-conceived, effective responses to institutional care in India are to be developed, critical engagement with residents' care experiences within these institutional paradigms is necessary. This will help to identify the improvements needed in the present condition of institutional care for older people in India. Against this backdrop, my study explores the experiences of residents in care homes in India, while limiting myself to homes in Goa. Hence, at the onset, I agree that the experiences of residents from other parts of India may differ. However, many of the voices do echo the realities of residents' lives in care homes in the rest of India. I do not go on to claim anything more than this.

Figure 1.1: Map of Goa



Source: Goa Vibes, 2009

1.3. Research objectives

This study has five main objectives:

1. To study the structure and functioning of care homes in Goa
2. To investigate the understanding and opinions of residents in these homes regarding their experiences of care received in them.
3. To gain an understanding of the experiences of residents at different phases of their residential career care homes.
4. To understand the staff and management perspectives on residents' experiences in care homes.
5. To determine the areas within care homes which require improvement and to recommend measures to achieve improvement.

1.4. Structure of the thesis

In trying to achieve the objectives stated in the previous section, the thesis embraces the following structure:

In chapter 2, I review relevant literature on institutional care for older people and this provides the platform for my thesis. I begin by discussing the demographic, policy and socio-historical context on ageing and care homes. The changing discourses on institutional care and the major policy frameworks that have formed

these discussions in the world, in India, and in Goa are highlighted. I also discuss the theoretical frameworks that have shaped discussions about older people's institutional experiences in this study – dependency, loss, agency, and departure in the form of death, leaving or hospitalisation.

Chapter 3 analyses the methodological, ethical and practical issues involved in my ethnographic fieldwork and my personal reflections upon the entire process. This chapter reflects a personal narrative about how I became involved in the field, what my feelings were and how my involvement and feelings changed as the work progressed. These personal reflections were important in my study because of the stress that I experienced in moving among the residents of the three care homes while trying to see the world through their eyes. I was subjected to many sad stories: rejection, broken promises, physical and emotional pain, desolation and dying. The historical truths of these stories were unascertainable and sometimes suspect; the acute depression that underlay them was unmistakably true and communicated itself readily to me. The problem of becoming personally involved was dealt with by discussion with my supervisors and colleagues which helped me to identify my prejudices and to regain some detachment. All these aspects are the focus of this chapter.

In chapter 4, I set out a detailed analytical description of the three care homes in order to provide a background for the analysis.

Chapter 5 deals with the pre-entry stage of the residents. The reason why older people move into care homes in Goa is analysed within its cultural context. The changing family system and its associated fallouts – stigma, abuse and rejection – provide the theoretical backdrop to this chapter.

In Chapter 6, I explore the entry process of residents in care homes in Goa by means of two theoretical discussions: 1) losses incurred by the residents as a result of moving into the home and 2) the different ways in which institutions exercise control over residents at entry.

The next two chapters deal with the post-entry phase of the residents. In Chapter 7, I discuss how institutional power structures and staff practices constrain the lives of residents. This chapter takes a critical approach, exploring the ways in which power structures and staff practices within the care home define and limit the

residents' choice and autonomy by instituting dependency and passivity in residents. Stopping the analysis here is inadequate. Hence, by using the rich literature on identity, resistance, and power, chapter 8 demonstrates the workings of agency within the care homes. It illustrates how residents attempt to resist institutional identities and create a personal identity that is not solely defined by the institution.

Chapter 9 focuses on the perceived forms of departures within care homes. Using the relevant literatures on transfers, hospitalisation and death, I illustrate through my ethnographic data how these perceptions and preparations for departure are defence mechanisms used by both the residents and the staff as extensions of their struggle for survival, freedom and control in the care home.

In chapter 10, the conclusion of the thesis, I draw together the threads of my arguments and summarise them. Unable to offer quick panaceas or long solutions, my conclusions nevertheless show that there is room for improvements both at policy and practice level. Hence, I discuss the policy and practice implications of my study. I conclude with some suggestions for future research.

Pseudonyms are used to refer to all names and places across all the chapters. Although in my study, certain parts may show harshness, sadness and insensitivity, they are included not as an attack on the homes but from my belief that such homes are needed, that they can be good places to live in, and that a clearer understanding of processes that take place within them is essential.

1.5. Conclusion

This chapter has presented the objectives of my study, the rationale for the study, its importance and the structure that my thesis will take in the subsequent chapters. It has also provided a brief overview of ageing and institutional care so as to introduce the reader to relevant issues around them in the world and India. These details are given in order to introduce the research environment. The next chapter will detail this further so as to enable readers to enter into the world of residents in care homes in order to appreciate their stories and experiences related in the ensuing chapters.

Chapter 2: Review of Literature

2.1. Introduction

The ageing of the population as reflected in the introduction to the thesis has both policy and theoretical implications. Policy-wise, it reflects the greater amount of quality institutional care necessary to meet the growing needs of older people who lack any other alternative care. Theoretically, it exemplifies numerous concepts associated with institutional living which illustrate the lives of older people within care homes. In this chapter, by examining the existing literature, I situate my research within a broader framework of literature on institutional care. In so doing, I divide this chapter into two sections. In the first section I review the empirical literature on institutional care in the world, in India, and in Goa, thus outlining the demographic, policy and socio-historical contexts for my study. In the second section, I draw a theoretical framework by locating the gaps in the existing literature on the key constructs used in the analysis of this study.

2.2. Setting the Context

As indicated in the introduction, the changing socio-economic and cultural conditions alongside an ageing population are having foreseeable implications for the expansion of institutional care for older people. This section aims to contextualise institutional care of older people. It is divided into three sub-sections. The first will highlight the demographic overview, the second will unpack the policy context and the third will provide a socio-historical context to ageing and institutional care.

2.2.1. Demographic context

A combination of high fertility and declining mortality during the twentieth century has resulted in rapid increases in older populations as successively larger cohorts step into old age. Further, the sharp decline in fertility experienced in the twenty-first century is bound to lead to an increasing proportion of older people in the future. As indicated in the introduction, the United Nations (2009) estimated that there were 737 million older people globally, and projected that this number will increase to 2 billion by 2050. The developing countries have had the largest share of this percentage since the 1990s (Rajan, 2006). By 2050 India (along with China),

will share the largest proportion of the world's older population (Rajan *et al.*, 2003). In absolute terms, India's older population is expected to increase from over 100 million in 2011 to 327 million in 2050 (Government of India, 2011).

The population dynamics of India's changing age structure are rooted in the combined impact of increasing life expectancy and declining fertility. According to the Government of India's 2011 census, life expectancy in India climbed from 37 years in 1950 to 65 years in 2011, reflecting a decline in infant mortality and the survival to older ages in response to public health improvements. By 2050, life expectancy is projected to reach 74 years. Fertility rates in India have declined to 2.6 children per women, less than half of the early 1950s rate of 5.9 children per woman (Haub and Gribble, 2011). According to the 2011 census survey, the proportion of older people in the population of India rose from 5.63% in 1961 to 7.5% in 2001 and to 8.6% in 2011 and is likely to reach 12% in 2031 and 17% in 2050 (Government of India, 2011). The 2011 census also indicated that this proportion was not typical for all the states in India – some states had a higher proportion of older people than the national average. These included Andhra Pradesh, Goa, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Orissa, Punjab, Tamil Nadu, Uttarakhand and Pondicherry. Among the larger states it was Kerala and among the smaller states it was Goa that took the lead in demonstrating high proportions of older people.

Goa's declining infant mortality, fertility, and adult mortality are typical of populations in the advanced phase of demographic ageing (Government of Goa, 2007). According to Government of India, 2011 census, the proportion of people aged 60 years and above in Goa lay at 10% above the all-India figure of 8.6%. Panandikar (1985) had pointed to this different nature of Goa's population when the trend was just beginning to emerge in the 1980s. Moreover, the 0-14 and the 15-34 population groups in Goa were smaller in size than the rest of India. Both realities have been attributed by Saxena (1974) to the high emigration from the region coupled with the pattern of returning home in old age. They were accompanied by a decline in the birth and death rates: the birth rate declined from 33 in 1961 to 13.3 in 2011 and the death rate from 13.39 in 1961 to 6.7 in 2011 respectively according to the 2011 census (Government of India, 2011).

This increasing number and proportion of older people is having an increasing impact on the demand for care services for them in the world, India and Goa. This profound shift in the share of older people – taking place in the context of changing family relationships and severely limited old-age income support – brings with it a variety of social, economic, and health care policy challenges.

2.2.2. Policy context

Beginning with the Universal Declaration of Human Rights, going on to the many International mechanisms – including the Covenants on Economic Social and Cultural Rights, on Civil and Political Rights as well as the Convention on the Elimination of All Forms of Discrimination against Women – there are many references to the rights of all (United Nations, 1948, 1966a, 1966b, 1979). The Declaration on Social Progress and Development in 1969 for the first time specifically mentions old age in Article 11 (United Nations, 1969). The Vienna International Plan of Action on Ageing, adopted in 1982 is the first international document on ageing, created by the first World Assembly on Ageing, and endorsed by United Nations General Assembly. It is developmental in focus, outlining principles and recommendations on areas such as the family, social welfare, health and income security (United Nations, 1982). General references are made to human rights via the reaffirmation of the applicability of the principles and objectives of the Universal Declaration of Human Rights to older people (National Human Rights Commission India, 2011). It took until 1991 for the United Nations to adopt the United Nations Principles for Older Persons focusing on five main themes: independence, participation, care, self-fulfilment and dignity of older people (United Nations, 1991).

The Committee on Economic, Social and Cultural Rights adopted the General comment number 6 on the Economic and Social, and Cultural Rights of Older Persons in the year 1995. This comment emphasised the rights of older people to social security by the state, protection from family, and right to an adequate standard of living (United Nations, 1995). In 1999, with the International Year of Older Persons, came the Conceptual Framework based on the Plan and Principles with four priority areas: (1) The situation of older persons, (2) individual lifelong development, (3) the relationship between generations, and (4) the interrelationship of population

ageing and development (United Nations, 1999). Finally, in Madrid in 2002, 20 years later, the 2nd World Assembly on Ageing adopted unanimously a Political Declaration and an International Strategic Plan of Action on Ageing. Both the documents include clear objectives and related actions to be taken: (i) to ensure the Rights of older persons, (ii) to protect older persons from neglect, abuse and violence in all situations addressed by the United Nations as well as (iii) to recognise their role and contribution to society. It contains three priority themes: development, health and well-being, and enabling environments (United Nations, 2002a). The Madrid International Plan of Action on Ageing 2002 (MIPAA) goes into great details on the situation of older persons and the Commission for Social Development was given the charge of implementation. The International Federation of Social Workers (IFSW) has drawn on the MIPAA to develop the IFSW 'International Policy on Ageing and Older Persons' (IFSW, 2009). This policy translates recommendations from the United Nations' MIPAA for social workers worldwide. As an international agreement that promotes the inclusion of older persons in all social and economic development policies, the MIPAA aims to ensure security and dignity in old age as well as the continued participation of older persons in their societies as citizens with full rights (Hokenstad and Restorick, 2011). The MIPAA has been approved by 151 countries. Both governments and international Non-Governmental Organisations (NGO) have been encouraged to take an active role in the implementation of the Plan of Action. The IFSW 'International Policy on Ageing and Older Persons' gives attention to all three priority directions of the MIPAA, including: (1) older persons and development; (2) advancing health and well-being into old age; and (3) ensuring supportive and enabling environments (Hokenstad and Restorick, 2011; IFSW, 2009).

However, it is obvious that these precedents are not enough to give older persons their rights as well as recognition of their contribution to society. The National Human Rights Commission, India (2011) cites examples to support the above argument:

1. The migration of young people from developing countries, or countries in transition with little or no welfare, leaves behind older persons with no social, economic and care support, thus increasing their vulnerability, isolation, poverty, discrimination and lack of health care;
2. The galloping technological development increases generation-divide: the older generations are too often excluded and affected by the digital divide;

The reinforcing point is that, in all issues, the right to development does not account the generation specificities of development over the life span and until the end of life (National Human Rights Commission India, 2011). To generate public attention concerning the mainstreaming of older persons, the theme chosen for the International Day of Older Persons in 2003 was 'Mainstreaming ageing: forging links between the Madrid International Plan of Action on Ageing and the Millennium Development Goals' (United Nations, 2003). Various United Nations programmes, specialised agencies as well as NGOs have made efforts to mainstream the concerns of older persons into their respective agendas. On the level of operative action, the United Nations Population Fund (UNPA) strives to mainstream ageing into its areas of work, such as reproductive health, gender issues and humanitarian responses to conflict situations (UNPA, 2004). World Health Organisation's major mainstreaming objective is to focus on principles and methods of developing health care systems that are responsive to ageing (World Health Organisation, 1999). The 2004 report of the Secretary-General to the General Assembly recommends that there should be assigning of "full-time focal points on ageing" which should be provided "with adequate resources to further implementation, particularly through appropriate mainstreaming action" (United Nations, 2004:2)

In India, the role of the state in providing care for older people was felt after Independence in 1947, when the Directive Principles in the Constitution that came out in 1950 emphasised the 'responsibility of the state within its capacity to care for the old'(Government of India, 1950: Article 41). In 1982, India stated its first draft policy for older persons in a report presented to the World Assembly on Ageing at Vienna in 1982 (United Nations, 1985: 137-179; Government of India, 1982). Besides emphasising the responsibility of the family in caring for older people, it declared that 'ageing in India should not be viewed with anxiety nor should the old

be considered an exclusive group needing separate institutional care'. Shah (1998) defends this stance by arguing that considering the variety of vulnerable individuals in India, isolating the old alone would not be sensible since the state of the economy, the country could hardly afford it.[1]

There is a dearth of policy and legislation explicitly referring to aged care in India. In the two directly linked documents to this issue – the National Policy on Older Persons, 1999, and the Senior Citizens Act, 2007 – the Government of India explicitly sets out roles and responsibilities in older people's care: families take the lead in care-giving with some secondary support from the Government and NGOs (Brijnath, 2008). The point made is that

> "(it) is neither feasible nor desirable for the State alone to attain the objectives of the National Policy. Individuals, families, communities and institutions of civil society have to join hands as partners" (Government of India, 1999: 6).

The Senior Citizens Act, 2007, is intended to address the housing and care requirements of older people and to protect their economic wellbeing. Comprising seven chapters and 32 sections, the Act stipulates that first and foremost children must care for their parents. In the absence of descendants, the Government should ensure that beds are available in care homes. A broad definition is taken of parent-child relations: a child may include biological, adoptive, and step-kin alongside those who might potentially inherit property. Elderly parents may apply to their children directly or via an authorised person for funds for food, shelter, clothing, and medical treatment. Children are legally obliged to supply such funds:

> "the obligation of the children or relative, as the case may be, to maintain a senior citizen extends to the needs of such citizens so that senior citizens may lead a normal life" (Ministry of Social Justice and Empowerment, 2007: 4.2).

Should descendants avoid their responsibilities, redress may be sought via a Tribunal which can authorise them to pay up to Rs. 10,000 (£100) per month as maintenance depending on their monthly income.[2] Those who fail to comply may incur a fine of Rs. 5000 (£50) or a jail term of three months, or both. The Act applies to Indian

[1] The argument is put forward by Shah that when even developed countries are returning to family care because of failed institutional initiatives, then why India should repeat these failed policies.
[2] Average monthly income in India is Rs. 5130 (£51) (Government of India, 2013)

citizens within and outwith India, and should children be residing overseas, they may be served with legal summons by the tribunal through the Government of India. The Act stipulates no role for either police or legal representatives because the intent is on reconciliation not litigation. The Act has been ratified by 11 state governments, including Goa. Additionally, the Ministry of Social Justice and Empowerment, Government of India, is seeking to implement 'An Integrated Programme for Older Persons' by partnering with NGOs and other organisations to set up care homes, dementia-specific facilities, medical mobile units, physiotherapy clinics, and the like for supporting older people (Ministry of Social Justice and Empowerment, 2008). In addition to sharing the above policies the Government of Goa has implemented the *Umeed* (hope) scheme in Goa which provides Rs. 2000 (£20) to every older person who is of Goa origin and is currently a domicile in Goa.

Having gained an impression of the policies in place, I now turn to elicit the socio-cultural context of care that is available for older people internationally – by focussing on Europe where issues are well documented – and locally.

2.2.3. Socio-cultural context

The conventional living patterns among older people have changed drastically following the reduction in fertility and the increase in life expectancy at older ages (Rajan, 2006). These trends elicit concerns about a gap in housing, care, and support of older people. The gap is being bridged, to some extent, by institutional care. More older people than before are seeking institutional care in the absence of home-based care

Institutional care of older people can be traced to the early Christian commandment of mercy and compassion. The Christian church established institutions called *Gerontochia* in the third and fourth century for the aged in many parts of Europe (Townsend, 1962). In England, by medieval times, there were 'Houses of pity' for the aged run by religious groups living under monarchic rule (Webb and Webb, 1927). This system was later broken up with the establishment of the Reformation Parliament.

The Poor Relief Act of 1601 legislated for 'poor houses' to be set up throughout England to provide for the destitute and thus became the successors of those 'Houses of pity' run by the religious groups. However, the ethos of these

homes was harsh because 'if the staff had been kind and sympathetic rather than repressive and if the food had been better, more people would have applied for admission' (Townsend, 1962:14). Nevertheless, the point is that, in Europe, institutional care was born as a result of an interrelationship between welfare response, poverty and destitution (de Beauvoir, 1972).

During this period, institutions were called 'almshouses' 'poor houses', 'workhouses', or 'houses of correction' depending on their purpose. In the 20th century institutional care was remodelled to reflect other forms of social structure, such as in factories, that is, the pattern of industrial organisation where workers congregated together under systematic control (Hughman, 1994). This was witnessed in the growth of mental asylums, prisons, and workhouses (Scull, 1979; Foucault, 1977; Nirje, 1976; Goffman; 1961).

It is against this background that the institutions for the care of older people emerged (Daatland, 1992; Clough, 1981). Still, the roots of the contemporary expression of institutional care for older people can be traced to the legacy of care in the Poor Law and the associated workhouses, which were viewed with a mixture of fear, dislike and cynicism (Townsend, 1962). A blunt observation in the same vein was made by Stern (1947:36-37) of homes for the older person:

> "unlike some primitive tribes, we do not kill off our aged and infirm. We bury them alive in institutions. To save our faces, we call the institutions 'homes'– a travesty on the word".

Thus during the 1940s and 1950s institutional care of older people was negatively conceived in the intellectual and popular debate.

The end of the Second World War encouraged thinking towards a more just and caring society (Bond *et al.*, 2007). Issues of older people with regard to access to health care, housing provision, and pensions were highlighted in the Beveridge report in the United Kingdom (UK) (Beveridge, 1942). The poor conditions in which many older people were living and the need to make changes in future residential provisions were particularly stressed in the Nuffield report (Nuffield Foundation, 1947). The recommendations led to the emergence of smaller homes for the aged. However, the promises to revamp institutional care for older people were not totally met. Peace *et al.* (1997) argue that the revamping consisted basically of upgrading

the workhouses and converting old buildings into residential institutions for older people, which continued largely to carry the stigma of the workhouses.

As a reaction to these continuing criticisms, attempts to emphasise individual needs, flexibility, and staff interaction with residents were stressed in the 1980s (Clark and Bowling, 1989). In France and the UK this was sought through development of links with community groups, such as social clubs and encouraging religious organisations to participate in the caring of older people (Pitaud *et al.,* 1991). In Germany, the Netherlands and Sweden, restructuring of institutional care has been more radical as older people and their younger relatives are encouraged to regard facilities more like ordinary living arrangements (Kraan *et al.*, 1991). Institutional care has also been opened up to the community through the provision of services to people who are not actually residents (Willcocks *et al.*, 1987). For example, in the Netherlands a range of services, including meals and bathing, became available from residential centres (Kraan *et al.,* 1991). The implications of opening up the homes to the outside world can however be a contentious issue as such a move can prove to be unsettling to long stay residents and operate counter to their stability and privacy (Willcocks *et al.*, 1987). For example, the Wagner Report (1988) which reviewed institutional care for older people in the UK proposed that where day care is provided in the premises of institutional care, there should be a physical separation between it and the space of the residents. This addresses Goffman's (1961) point about institutionalising the use of space, as any attempt to normalise may be aimed at the resident going in and out as an individual who would be living in his/her home, and not as someone else perpetually coming into his/her home as a day centre.

This led to a serious rethinking on the lines of continuation of institutional care for older people. The trend in the last decade in many developed countries like the UK has been for a reduction in the number of care homes accompanied by an increased provision by the private sector due to open-ended income support funding. Policies in most developed countries are oriented for care to occur within the person's own home for as long as possible and to be undertaken by family carers with secondary support from the Government, NGOs, and paid attendants (Luppa *et al.*, 2008). To this end, initiatives such as home-care attendants, meals-on-wheels,

financial aid, and respite care are available to varying degrees and there is consensus that such services need to be expanded to enable people to age 'in place' for as long as possible even until death (Johansson *et al.*, 2009; Milligan, 2009; Cutchin, 2003).

This trend is also accompanied by regulations in the form of policies to regulate the standard of care services (including institutional care). In Scotland, for example, the policies include the Care Standard Act 2000 and Regulation of Care (Scotland) Act 2001. These Acts promote registration and inspection of care services against a set of national care standards which are consistent no matter where the service is located. These standards outline the quality of service that older people can expect, and inspections are conducted on a regular basis to ensure the consistency of the quality of service (Scottish Government, 2001).

These standards further operate on the principles of dignity, privacy, choice, safety, empowerment, equality, and diversity. This suggests a shift towards a Person Centred Care (PCC) model for older people in care homes in the UK. In a PCC approach the unique qualities of the individual, as determined by their life history and experiences, likes and dislikes, are their defining characteristics. The focus is on treating older people with dignity and respect. Care and support services are built on individual strengths and on abilities to maximise and promote independence (Brooker, 2003). Older people are thus supported not only to make informed decisions about, and to successfully manage, their own health and care, but also to choose when to invite others to act on their behalf. Assessment, care planning and reviewing are key aspects of judging whether a PCC is integral to the service provided. This model is opposed to the medical model which is only focused on the physical and biologic aspects of the individual (Laing, 1971). In the medical model the physician, carer or nurse is seen as the expert and the older person is expected to comply with their advice. The expert assumes an authoritarian position in relation to the older person. Under this model the physical condition of the older person is of major importance, and the social, psychological and other external factors which may influence the older person's behaviour is given less attention (Goffman, 1961). The PCC model on the other hand includes these factors in addition to the medical history of the older person.

However, even with these positive practices, problems of abuse continue to ail older people both in institutional and home-based care. According to the Toronto Declaration on Elder Abuse (World Health Organisation, 2002:3), elder abuse is "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person". Systematic interventions to monitor and screen elder abuse are in existence within countries; however, gaps in their implementation continue because of issues with reporting and monitoring abuse (Sykes and Groom, 2011; Lachs and Pillemer, 2004; Jamuna, 2003).

The above socio-historical context is crucial in providing a wider global historical context to locate the issues around older people and institutional care. However, it is important to locate this in the social context of India with its unique socio-cultural and demographic milieu.

Elder care in India has been traditionally organised under the joint family system[3] (Brijnath, 2012). The joint family system in India has been claimed to function as a micro social security system for older people for centuries (Gangrade, 1999). Older people are expected to be taken care of by their children based on intergenerational reciprocation and the importance of doing *seva* (Lamb, 2000; Vatuk, 1990). *Seva*, when translated into English as 'service', is a layered concept encompassing the intellectual, emotional, and physical care of elders by their younger family members. The concept is based on respect, with such care seen as a form of divine worship (Vatuk, 1990). The joint family system in India today continues its role of extending care and support to the elderly (Brijnath, 2012; Devi and Murugesan, 2006; Bhat and Dhruvarajan, 2001; Gangrade, 1999; Prakash, 1999). However, a series of developments, such as urbanisation, industrialisation, modernisation, westernisation and migration, and their associated characteristics of materialism and individualistic orientations, are claimed to have threatened the joint family institution of the past and weakened the filial obligations and mutual ties which are the hallmarks of the traditional joint family (Devi and Bagga, 2006;

[3] Multiple generations lived within a single household sharing income and resources (at least in theory).

Jamuna, 2003, 1998, 1987; Dube, 1999; Nayar, 1999; Cohen 1998:17; Singh, 1997; Bose, 1995; Ramamurti *et al.*, 1992).

Migration, whether in-country or overseas, tends to create more nuclear family units and often older family members are left behind (Varghese and Patel, 2004; Patel and Prince, 2001). The frequency of this trend had led to the formation of an acronym to define it: PICA – Parents in India, Children Abroad (Prince, *et.al.*, 2007; Prince and Trebilco, 2005). Women's roles have also changed from the past, with more women now in full-time paid employment leading to their reduced availability to care (Brijnath, 2012). Further, popular urban living, higher costs of living and increased consumerism leave many families overall less likely to meet the medical, social, financial, and psychological needs of their elderly relatives (Patel and Prince, 2001). Consequently, many scholars claim that older people are neither as securely positioned in their family's hierarchy nor as revered as past generations were (Mahajan, 2006; Jamuna, 2003; Kumar, 1996; Dharmalingam, 1994)

Although informal care by the family continues to be a major source of care for older people, the provision for the care of older people is increasingly being passed to the domain of institutionalised caring in the form of care homes (Lamb, 2009). Care homes have mushroomed in India since the 1990s (Shankardass, 2000; Jamuna, 1998, 1987; Mandal, 1998). Presently around 1014 care homes have been documented, of which 427 are free, 153 are on pay-and stay-basis, and 146 have both free as well as pay-and-stay facilities (Brijnath, 2012; HelpAge India, 2009). Information is unavailable for the remaining homes (HelpAge India, 2009). Alongside this, there is also a burgeoning of a commercial aged care sector distinguished from the typical care home by its explicit user-pays model (Liebig, 2003). Paid facilities encompass a wide range, beginning with basic services (like food and shelter) at Rs. 6,000 (£60) per month to luxury accommodation with Ayurvedic spas and on-site pharmacies at Rs. 25,000 (£250) per month (HelpAge India, 2009; Lamb, 2009). In contrast, care homes which are the face of institutional care in India, are spaces for a majority of the older people in India lacking home-based care, who are perceived as abandoned by their families because of conflict or abject poverty. These places are free of charge or with minimal charge and are predominantly managed by the Government, NGOs, charities, and religious groups

(Brijnath, 2012). Food, shelter, and other basic amenities are provided to the residents (Liebig, 2003). All three types of homes tend only to admit people who are physically and mentally competent (Brijnath, 2012). In the event of severe or debilitating illness requiring intensive care, residents are referred to hospitals, or families are requested either to provide a private attendant to allow the person to stay or to take the person home (Lamb, 2005).

Despite the rapid growth of care homes across India, there is stigma associated with entering, and living in, a care home. Care homes are seen as a symbol of social degeneration, where aged relatives are abandoned, and love and service as an inherent feature of family care is now commercialised (Kalavar and Jamuna, 2008; Jamuna, 2003; Bhat and Dhruvarajan, 2001) Residents of care homes are thus viewed as abandoned by their families and very often referred to as 'inmates' by staff and management (Lamb, 2009, 2005). In describing the discourses circulating in care homes in India, Lamb (2005:80) notes that

> "Indians take such emerging and novel modes of serving the ageing to represent a profound transformation – a transformation involving not only ageing per se, but also principles underlying the very identity of India as a nation and culture".

The argument is that, despite the spread of care homes across the Indian landscape, these institutions are negatively stereotyped as intrinsically public, communal, and routinised (Bond, 2007). However, the unease in India is often associated with the notion that moving into a care home indicates the last stage of an older person's life and an inadequate family support system (Banerjee *et al.*, 2003; Eaker *et al.*, 2002). In this light, care homes are spaces that symbolise an abrogation of familial responsibility. This creates a stigma against care homes in the minds of both the family as well as older people (Brijnath, 2012; Lamb, 2009, 2005; Kalavar and Jamuna, 2008; Jamuna, 2003). These studies point out that stigma is a result of associating entry into care homes with abandonment, family conflict, and psychological distress.

Institutions as discussed above not only represent the organisation of society but also embody "how society groups and values people" (Peace *et al.*, 1997:61). Goffman (1963:3) articulates how an individual's condition that departs from the

"ordinary and natural" – in this case an individual's old age and his/her entry into care homes – are deeply discredited. The person is reduced in the eyes of others "from a whole and usual person to a tainted, discounted one". This culturally dominant negative categorisation gives people stigmatised identities (Goffman, 1963). The bearers of a stigmatised identity recognise the definitions which are directed to them, but it is understandably difficult to accept such a position (Juhila, 2004).

Goffman (1963) characterises stigma as a mark of social disgrace, arising within social relations and disqualifying those who bear it from full social acceptance. These marks take various forms: physical deformities, mental illness, unemployment or distinct religious or ethnic identities. People who possess such characteristics acquire a 'spoiled identity' associated with various forms of social devaluation (Campbell and Deacon, 2006). According to Jacoby and Austin (2007), stigma operates at different levels: internalised, interpersonal, and institutional. Internalised stigma is felt within the person with the specific mark and reflects their feelings, thoughts, beliefs and fears about being different. Interpersonal stigma occurs in interactions with others both within and external to the family system; and in these interactions the person with the mark is treated differently and negatively because of the mark. Institutionalised stigma reflects indirect expressions of different treatment of persons with a mark as a group in the larger society.

Bearing on the above explanations, stigma in this thesis is very much about the socially constructed meanings associated with old age dependency and care homes. By conveying the devalued status of older people living in care homes relative to those living with their families, stigma defines social roles within interactions (Goffman, 1963). The inferior social status of stigmatised individuals means that they have less power than the non-stigmatised and less access to resources valued by society (Herek, 2008; Blyth and Moore, 2001). Based on these considerations, stigma is a socially shared construct about the devalued status of older people living in care homes. It is manifested by prejudice, discounting, and discrediting as directed towards older people in care homes. Because the meanings attached to any prejudice are created through social interactions (e.g. experiencing mistreatment or learning of other people being mistreated), this experience of stigma

can vary across cultures. For example, whereas stigmatizing attitudes against older people in care homes have declined in the West they remain more overt in the East particularly in countries like India where the family is seen as the primary care giver.

On the other hand, studies have challenged the stigma theory by arguing that older people in India are more insecure in their families than in care homes (Mahajan, 2006; Jamuna, 2003; Kumar, 1996; Dharmalingam, 1994; Varadharajan, 1989). Davies (1989:79) argues that viewing "institutions as oppressive and opposed to the individual" is a distinctive feature of Western societies. He bases his argument on the illustration that in non-Western societies like India, the difference between the joint family which acts in an authoritarian and controlling manner and that of an institution is less, and hence the institution may not be viewed as nurturing dependency in residents. Furthermore, the institution can be less authoritarian and allow more freedom than the joint family so that the experience in an institution may be considered a liberating one (Davies, 1989). Jamuna (2003) speaks about the high prevalence of elder abuse in families in non-Western societies like India, so that an entry into a care home can be experienced as a much-awaited freedom. The illustration in Delaney's study (Gordon and Williams, 1977:18 in Davies, 1989) of the Buddhist temple having characteristics of a total institution also contributes to a non-Western understanding of an institution. The results of Delaney's study are contrary to those emphasised by Goffman and other scholars, that is, instead of creating dependency in residents, the resources and power of the institution, in this case the temple, can be used to protect the individual from an unsympathetic society.

Few studies have been undertaken to understand the conditions of older people in care homes in India (Das and Shah, 2004). In the mid-nineties a few quantitative studies were carried out, focusing on care homes in specific states in India (Rajan *et al.*, 1999; Sharma, 1999; Ramamurti *et al.*, 1996; Morgan, *et al.*, 1995; Sharma and Xenos, 1992). They reported on resident satisfaction, quality of care, and to a smaller degree management issues, and concluded that there is a need for improvement in the quality of care. All these studies have exposed deplorable conditions, such as insufficient or unsatisfactory food and lack of facilities in the homes. They highlighted problems with the quality of care along similar lines to those highlighted in the UK studies of Townsend and others in the 1960s and 1970s.

In addition, they also exposed an absence of standards or guidelines for care homes in India.

In the study by Devi and Murugesan (2006) on care homes in India, it was highlighted that the older people had their basic needs satisfied but experienced a huge void in meeting their psychological and social needs as a result of regimentation, social inactivity, helplessness, lack of interest, boredom, and loneliness. However, a study of a care home in Maharashtra conducted by Dandekar (1993; 1996) showed the residents expressing contentment with their stay there compared with their own homes where they felt ill-treated.

Liebig (2003) in her study reflects four responses from residents about care homes:

1. Attempts by the Government, religious organisations and private firms to create institutional care for older people. They can promote social isolation from society and ignore older people's emotional needs and thus they should not be encouraged.
2. Institutional care is the last resort, that is, in the absence of family support and while the elders are capable of caring for themselves, the care home can meet some of the unmet needs of the older people.
3. Institutional care is the only viable solution to keep up with a growing elderly population.
4. Institutional care in India is very much needed but needs to improve its quality of care.

In Goa, institutional care is the most widespread form of formal care for older people. With its roots stretching back to the 18th century under the Portuguese colonial rule, the development of institutional care for older people in Goa has been influenced by changes in the different social, political, professional and traditional factors after liberation (Research Institute for Women, 2002). Goa has approximately 112, 000 older people of whom 3% live in care homes which is higher than the national average of less than 1% (Government of Goa, 2007; Liebig, 2003). The network of care home in Goa has grown from 5 homes in 1961 to 52 homes in 2010 (Sousa, 2010; Research Institute for Women, 2002). Their location is spread throughout the geographical area of Goa, though many rural areas lack care homes.

The total capacity of the homes is 3,200 beds. Their sizes range from 20 to 80 beds with the average being 45 beds (HelpAge India, 2009). The residents are aged between 60 and 90 years. As noted in a study by Research Institute for Women (2002), the homes appear overcrowded. Another finding in the same study noted that there are more homes in Goa for women than men: 12 homes are for women only as opposed to 5 for men and the remaining have a mixed population.

The care homes in Goa can be divided into three main categories: state, religious, and private. The first category is managed by the Government department titled Provedoria, also known as the Institute of Social Assistance. They have existed since colonial times. The second category consists of homes started in post-colonial times by religious organisations and lay organisations, such as St. Vincent de Paul and Pao de St. Antonio, in houses donated by families living abroad or couples without immediate heirs, and in old convents. In the third category are homes run by Private Trusts set up by individuals, charity groups or NGOs. These homes are fairly recent; the first private home was built in 1991.[4] In terms of financial contributions by the residents in these homes, the classification likewise falls into three groups, that is, residents who pay for their stay and food, residents who partly pay, and residents who do not pay at all. Care homes in Goa operate both as a nursing and a residential home which distinguishes them from the present form of the European welfare system based on its separation of institutional help according to purpose. Another typical feature of care homes in Goa is that most residents are able bodied (mentally and physically) and are in the homes as a result of lack of any care alternatives (Souza, 2010). Patel and Prince (2001) exposed the fact that care homes in Goa as a rule did not admit those with permanent disabilities and specifically excluded those with dementia. The care homes claimed that this was the case because they do not have the facilities or the manpower to care for high-dependency individuals. There was, therefore, no local continuing care provision for those with dementia, or for those who lacked both family support and financial means. According to a quantitative study by Research Institute for Women (2002: 40-44) to evaluate the services and the facilities in care homes in Goa, the majority of care

[4] This was the same year that the Indian economy was liberalised.

homes did not have adequate facilities. They are "small, poorly lit, depressing and are not very hygienic".

The assumption manifested in care homes in Goa is that older people only have physical and health needs (physiological needs). They either do not, or have very modest, social and 'higher level' needs, such as the need to influence their surroundings and to have a say in decisions concerning them, as reflected in Maslow's hierarchy of needs (Souza, 2010; Maslow, 1943), the implication is that the medical care model is more popular than PCC. Little thought is given to social activity, leisure, recreation, education, or creative activities and if and where they exist they can be very dull and excessively structured (Souza, 2010). The issues implied in these quantitative studies point to a regimented and homogenous life for residents in care homes, isolation from society, and desolation (Patel and Prince, 2001).

2.3. Towards a theoretical paradigm on institutional living

An individual's existence today can be seen as evolving within institutions. This is illustrated by Mali (2008:432):

> "[M]en are born at a maternity hospital, are employed in companies, become members of clubs and finally move to care homes."

The importance of the difference between the institutions that are the focus of this research and other social units in society that are also referred to by scholars as institutions in their own right is the fact that these institutions are lodged within the confines of a single building. They aim to "achieve clear stated goals in terms of the care of the individual, following rules and regulations and having a control management" (Mali, 2008:432). The outcome as evident in various studies which will be discussed below is that the institution determines a large part of the individual's life, while the individual has only a small voice. Thus 'institution' here is not only a categorical ascription but also a critique (Hughman, 1994).

In recent years, there has been increasing research related to older people and institutional care (e.g., Paterniti, 2003, 2000; Phinney, 1998; Gubrium, 1993). Although much research in the past was focused on biomedical issues, more recent research has expanded to include psychosocial issues (Wiersma, 2007). The population growth of older people as well as the growth in incidences of issues

related to older people may have contributed to this increase, but so has the increasing professionalisation and disciplinisation of the field of gerontology (Katz, 1996). Despite the increase in literature and research on ageing and institutional care, there are still many gaps in our understanding of these phenomena. In particular, the issues of loss, dependency, agency, and departure in relation to institutional care have received limited attention over the last decade or so, and little systematic attempts have been made to link these concepts together, especially with relation to older people and institutional care. The focus of this study, then, is to examine the process of institutional living, by focussing on the above mentioned constructs. The subsections below will introduce these issues in an attempt to arrive at a theoretical framework for this study. However, a deeper discussion on each of these constructs will take place in the analysis chapters (Chapters 5 – 9).

2.3.1. Loss and Dependency

Research on older people entering care homes has shown that when they are exposed to this relocation, there is an increase in their physical and psychological problems, feelings of being a burden, loss of control and helplessness (Johannesen, 2004; Johannesen *et al.*, 2004; Scott, *et al.*, 2003; Svidén *et al.*, 2002). These feelings intensify when the move is involuntary (Lee *et al.*, 2002). Furthermore, research points out that as a result of this entry, making choices and decisions in daily life risk becoming a lost ability and opportunity in the minds of older people (Scott, *et al.*, 2003). This element of dependency is further deepened in older people as a result of the losses associated with, and during, their relocation to institutional living.

As I pointed out in the introduction to this thesis, sociological research by Barton (1959), Foucault (1967) and Szasz (1961) noted the deterministic tendency of residential institutions whereby there are some external stimuli that actually determine an individual's life and self, and in this case it is the institution itself. Goffman's (1961) work similarly showed a tendency towards a deterministic viewpoint when talking about such institutions. This is manifested in his description of institutions with certain characteristics as 'total institutions' (including care homes which show tendencies towards these characteristics). He described these institutions as places of residence where individuals are isolated from the wider society. The life of the resident is carried on in an "enclosed formally administered manner time".

This led to what he called “mortification of the self” that is the “forcible erasure of the self-identity of the resident by the pattern of life in the institution” (Goffman, 1961:16-21).

These studies emphasise the dependency created by institutions which leads residents to depend completely on the institution for their daily activities and relationships. The implication is that through institutional care, these institutions, because of their restricted and controlling nature, produce passive and dependent residents (Booth, 1985). Consequently, on the one hand, they take care of all the needs of residents and, on the other, “regimentation reaches into all spheres of a resident’s life” (Mali, 2008:434). The residents are treated alike in groups and are required to do the same things together with one activity leading to the next activity all of which is pre-arranged along with the time schedules (Goffman, 1961). In other words, there is a lack of variation in the daily routine. Such a characteristic is called group living, ‘batch living’, or ‘block treatment’ (King and Raynes, 1968; Goffman, 1961:13-22). Another typical characteristic described by Goffman is ‘binary management’. The term suggests that the staff and residents have different points of view and may come to perceive each other in ‘narrow, hostile stereotyped’ ways where the staff feel ‘superior and righteous’ in relation to feelings of being ‘inferior, weak, blameworthy, and guilty’ expressed by the residents. This eventually results in a ‘social distance’ between the staff and residents. The above characteristics are manifestations of institutional power and controls that act against the identity of residents. This is referred to by King and Raynes (1968:42-44) as ‘depersonalisation’ where residents have limited personal possessions and privacy. The manifestation of this depersonalisation is found not only in terms of loss of personal possessions, such as clothing, but also intrusion into one’s privacy and submission to demeaning practices. This intrusion includes being required to eat all of one’s food, forced feeding, eating in a particular manner, being placed under a strict surveillance programme to teach behaviour, being controlled by rules, regulations, judgements and sanctions, having to ask for little things like water, or just being considered insignificant for an exchange of greetings (Lemert and Branaman, 1997; Clark & Bowling, 1990:1202, Wallace, 1971).

Studies have further pointed to the entry into a care home as being associated with loss of possession, relationships, and autonomy (Frank, 2002; Kellet, 1999; Lee, 1997; Wilson, 1997; Szeman and Sik, 1991). In his study based in Oklahoma, USA, Nussbaum (1993:241) described entry into a care home as "…a highly structured, government regulated event that often occurs in a hurried atmosphere of heightened stress". In this process, the staff members were explaining procedures that were not negotiable. "Information flowed from the staff and the submissive potential resident quietly listened" (Nussbaum, 1993:244). The result of the interactions was the enforcement of dependency. The author concluded that the outcome of resident-staff interactions prior to admission indicated that to a new resident, a move into a care home meant a move to total dependence. The admission procedure therefore acts as the first measure to assure compliance from its residents, thus manifesting the first elements of the institutional dependency (Goffman, 1961). The controls and regimentation manifested by care homes in these studies are positively correlated with the dependency of residents. In sum, group living philosophy, rigidity of rules and regulations, and those staff and management practices are seen as important characteristics of care homes. The residents are expected to conform to the rules and discipline, and their ability to make decisions or their right to have a choice is ignored or over-ruled, thus creating dependency and compliance in residents.

Various studies have used the above mentioned constructs – regimentation, group living, binary relationships, and staff practices – to describe institutional care and the life of residents in care homes (e.g., Mali, 2008, Hazan, 2002; Groger, 1995; Bowling and Formby, 1992; Bond *et al.*, 1989; Lowrey and Briggs, 1988; Clough, 1981; Wilkin *et al.*, 1978; Wallace, 1971; Pincus, 1968; Townsend and Wedderburn, 1965; Townsend, 1962; Goffman, 1961). They have identified and theorised specifically the negative perceptions associated with care homes and what characterises these perceptions. In doing so, other studies have also exposed many realities of institutional care, such as forcible bathing of residents, regimented mealtimes, lack of personal clothing, restriction of communication within and outwith the home, lack of general privacy, and the use of derogatory language by the staff towards residents (Means and Smith, 1994; Fennell *et al.*, 1988).

These characteristics, according to Townsend (1962), cause dependency and loss in residents, diminishing their identity which is already damaged due to the very stigma of being in a home. This argument by Townsend helps us to identify a gap in the above mentioned literature: although the institutional power and controls are extremely important in creating dependency and loss in residents of care homes, there exist other factors that contribute to the negative perceptions of institutional care and living. For example, Booth's (1985) study on local authority care homes in England highlighted a co-relation between the negative effects of institutional living and a need for increasing resources and staff training. Townsend's (1962) study on social deprivation in care homes in the UK argues that institutional care is a form of social policy which institutionalises ageism rather than a form of intervention seeking to alleviate individual problems and meet individual needs. This also reflects a critique of the dependency created by institutions as a conceptual framework. Hughman (1994:47) supports this by arguing that the attitudes reflected in institutional care for older people are "symptomatic of a wider ageism in society". Baldwin (1993) supports Hughman's critique by citing the emphasis placed on the internal workings of residential settings and the limited actions and roles of residents, ignoring the context that requires a residential home to function. His argument is built upon the defence that older people entering institutional care are already victims of the 'actions and dispositions' of those who devalue age in society. Thus, older people already have had an induced dependency as a result of the economic and social structures in wider society, and of the perception that age is associated with certain physical and mental deterioration and thus a loss of capability to exercise one's choice. Institutions only add to this set of influences which devalue older people further as they become residents. Although none of these studies negates the negative perceptions associated with care homes where the identity of residents is increasingly being defined by the institutional controls, they nevertheless point to the inadequacy of stopping the analysis at that juncture.

Scholarship on agency provides a useful corrective to some of the problems of the concept of dependency. Contemporary theorising emphasises agency in abusive, discriminating and dependent situations. The dependent grapple with their positions as victims of a socially constructed subordinate status, and at the same time

search for creative ways to resist sub-ordination. I aim to take this discussion forward in the next section.

2.3.2. Agency

The discussions highlighted in the earlier sections assert that the identity of a resident in an institution like a care home is defined by the institution and the conditions prevalent in it, with the consequence that there is very little opportunity for manoeuvre. As discussed above, most literature on care homes focuses on the miseries and passive existence of residents, thus ignoring their adult capacity to make choices and enact the personal agency typical of adult status in society (Morgan, *et al.*, 2005). The stigma theory does not offer the "possibility of any serious attempts by stigmatised individuals to de-stigmatise themselves," that is for the individuals in this case the residents of care homes to present their stigma as a difference rather than as a failing (Gussaw and Tracy, 1968:317)

While it is undoubtedly important to understand the stigmatised identities, difficult conditions and submissiveness of the residents' lives, it leaves the analysis incomplete as such a framework would conceal the subtle but persistent forms of resistance that residents practice. Institutional living can thus become a battle ground for the older person between one's individual identity and that of the organisation. At the same time, it can be a protector and liberator of the individual's self. The key to unravelling these complex relationships will require a greater understanding of the daily implications of the balance among dependence, independence, and interdependence for older people in residential settings (Peace *et al.*, 1997; Willcocks *et al.*, 1987:2).

Goffman has made reference to "[the] selfhood residing in the cracks of the solid building of the world" (Goffman, 1961: 320) and suggested that certain resistant stances are available. He defines the self as a "stance-taking entity, as something that takes up a position somewhere between identification with an organisation and opposition to it" (Goffman, 1961: 320). In other words, individuals rarely take extreme positions; they normally take a middle position in order to avoid complete identification of the self with their affiliation. They allow some disaffection to be seen while at the same time they fulfil some major obligations. It is through this identification and distancing that the identity of a participant in a social organisation

is defined (Scott, 1985; Goffman, 1961:180). Studies examining how people with 'flawed' identities manage their lives in institutions have uncovered strategies used by clients, homeless, prisoners, patients and workers to accommodate, negotiate and resist the efforts of institutions to alter the sense of who they really are (Horowitz, 1995; Snow and Anderson, 1993; Schmid and Jones, 1991; Goffman, 1961). Goffman (1961) believes that stigmatised individuals hold the same beliefs about their condition as the rest of society; consequently, dealing with stigma becomes the focus of existence. Empirically however, there are countless instances in which individuals disavow dominant perspectives – for example feminist scholarship on women's agency emphasise the situation where they face discrimination and abuse: women with disabilities confront and resist dominant views, women modify their reproductive lives as the need arises (Riessman, 2000; Abu-Lughod, 1990; Fine and Asch, 1988)

Studies on care homes as reflected above disregard residents as individuals who possess agency in their everyday struggles. The resident's attempts at reacting to the regimentation of the care homes would, for example, allow a fuller understanding of the extent to which the residents cope within the care home. This theoretical construct (agency) helps in locating everyday forms of resistance (Scott, 1985). By resistance, I mean the transformative actions which older people initiate in order to press their own claims in relation to others who discriminate against them. These acts of resistance cannot always be seen as seeking to transform the existing order. In many cases, these acts only uphold and reinforce the status quo (Jeffery and Jeffery, 1996). Thus, residents may consent to the controls of the care home rather than criticise, endure, or comply with its norms even if these are antagonistic to their interests. Hence the question is not whether residents are victims or agents, but what sort of agency residents can have despite their subordination (Jeffery, 1998). Thus, the dominated should neither be viewed as helpless victims within the oppressive structure nor should their agency be romanticised.

2.3.3. Departure

The struggle between the resident's compliance to institutional rules and his/her attempts to assert one's own identity is not everlasting; it ends with the departure of the resident from the home. Very few studies on institutions in general

and care homes in particular have explicitly studied the residents' departures from institutional living (Davies and Duncan, 1975). These studies are limited to evaluating the trends in the departures from the home, that is, the percentage of residents who leave the home as a result of transfer, hospitalisation, or death. Most of these studies are limited to looking at the departure of residents from the perspective of the institution and the staff, ignoring that of the residents. More importantly, they overlook the impact these departures have on the continuing residents – what do these departures mean to them when perceiving their exit from the home, and how do they cope and prepare for these departures? Miller and Gwynne (1972) have pointed to anxiety, insecurity, and fear in residents associated with departures. They have considered various mechanisms that are used both by the residents and the staff to cope with and anticipate these departures. It is the uncontrollability of such departures that leads them to a defensive search for coping strategies (Miller and Gwynne, 1972). Some of these strategies include: scapegoating of residents, denial of death by transferring residents to die off-premises, death as freedom from worldly evils, and belief in the afterlife according to the Christian and Hindu religious beliefs (Chopra, 2006; Deshpande *et al.*, 2005; Castle and Mor, 1996; Clough, 1981; Miller and Gwynne, 1972) An analysis of this is important for an understanding of how residents construct their own departure in care homes and how they prepare for it.

While understanding of older people pre and post entry experiences is abundant, there is scant literature on locating the above issues and tying these together in a narrative analysing residents' experience of institutional living. In my study I tie these concepts – loss, dependency, agency and departure – together to present a framework which will guide my research. I make assumptions of the oneness of the above constructs in determining institutional living of older people, which may be separated conceptually but not experientially. This study, then, not only takes an experiential approach to understanding people's experiences of the institutional living process in care homes in Goa, but also takes a critical approach to the ways in which culture and power define the experiences. The assumptions or understandings underlying this study are that these constructs – loss, dependency, agency, and departure – are intertwined, and that culture and power discipline these phenomena in addition to residents being active agents.

2.4. Conclusion

The contextual discussion in the first section (contemporary West, India, and Goa) helps to locate the study within a particular, contextual and policy framework. Additionally, the review of the prevailing literature on institutional living in general and care homes in particular provides a theoretical background against which I examine my data. In this review, I have introduced and minimally discussed the following themes: loss, dependency, agency, and departure as interrelated aspects of institutional living. They will be taken up for further discussion in my analysis chapters.

These theoretical constructs are the key concepts to be used for the analysis of this study against the backdrop of institutional living. The career of a resident in a care home – pre-entry, entry, post-entry and exit – is used as a narrative to discuss each of the themes. Thus the theoretical framework on which I will be relying in my five analysis chapters, revolves around the process of institutional living – the conditions (changing family system) that led older people to enter institutional care (chapter 6), the loss and dependency incurred while entering institutional care (chapter 7), the induced dependency created by institutional control and structures resulting in passive residents (chapter 8), and, the struggles of the residents to resist these power structures through subtle daily forms of resistance (thus documenting everyday life for the resident in the care home which exists within a framework of power) (chapter 9) and departure (different forms) as ending this struggle or beginning a new one (chapter 10). Each analysis chapter will explore the specific aspects of the residents' experience in entering and settling in the care home within a theoretical framework and drawing out implications by relying on the data collected from the field: pre-entry, entry, post-entry, and exit, bearing in mind the different stages of an older people's entry and adjustment to the care home. The ultimate aim is to understand the mechanisms in place for older people entering institutional care arrangement – the only form of alternative care arrangements in place for older people in Goa – and whether these mechanisms are adequately suited to their needs.

The review of literature has established a way forward for the study, not just in theoretical terms, but also in terms of practical insights into carrying out a study of

this nature. The next chapter will discuss the methodological approaches that were employed and the rationale for them.

Chapter 3: Methodology

3.1. Introduction

The previous chapter reviewed the literature around institutional care for older people. In this chapter, I set out my research questions, and outline the research process through which I attempted to answer them. In essence, I lay out the choices with which I was faced, the decisions which I made and the rationale behind them. I also describe my position in the research and the impact which it had on the data collected and analysed. A point to reinforce here is that reflexivity in my research has been an iterative process. Therefore, the reflexive narratives are interspersed throughout this chapter rather than placed in a separate section.

3.2. Research Question

Before setting out on my field work, I did have a clear sense of what I was looking for, namely, a deeper understanding of the care provided in care homes in a developing country, from the perspectives of its residents and of those responsible for their care, through a case study of Goa. The aspects which I was looking for were limited to viewing residents as passive and dependent and how institutional structures and controls contribute to this view as highlighted in the literature discussed in the previous chapter. It was only in the process of my field work that the specific questions of my thesis emerged – by spending time in the field and getting a sense of what the residents and staff considered important. These encounters led to specific questions which further supported the literature on which my research aim was based. However, some of them also challenged the passive understanding of the residents' lives in care homes and led me to explore a more nuanced understanding of older peoples' experiences in them.

The refined question thus is to examine the experiences of the residents in care homes in Goa as they have gone through the different stages of entering, settling and exiting these residential care settings. In so doing, several smaller conceptual issues also needed to be addressed.

1. What were the dynamics that helped to explain the reasons and process of entering a care home in Goa?

2. Does – and if so, how – the process of moving into a care home undermine and/or retain the ability of older people to retain a positive sense of identity and control?

3. How do institutional power structures and staff practices in these homes constrain and/or enable the lives of the residents in their daily lives within the home?

4. How is the agency (if any) of the residents understood and played out and what implications does it have in their lives?

5. What were residents' anticipations of the different forms of their own departure from the care home? How did the residents see themselves preparing for departure? What was the role of staff and management in the departure of residents and their preparation for this departure?

3.3. Qualitative research strategy

The research questions imply that this study was not primarily interested in the quantification of social phenomena (Flyvbjerg, 2006). It was explorative in nature, being particularly interested in capturing the respondents' everyday interactions and understanding how they construct meaning out of their life experiences in the care home. This, for me, could only be achieved by immersing myself into their daily lives, by talking to them and observing their interactions along with those who are a part of their lives and are responsible for their care and support (Blaikie, 2009: 120). Qualitative research is concerned with day-to-day relationships, perspectives and interpretations of people based on their lived experiences (Flick, 1998). It seeks to gain insight into the "thinking and behaviours" of people and the meanings that they give to their activities and experiences (Arksey and Knight, 1999:10). Hence, I used a qualitative research strategy to help me to obtain rich and descriptive accounts of older people's perceptions, experiences, feelings, and views.

On being asked how residents felt about moving to the home, for example, the responses from Violet and Felix, respectively, were:

> *"I am very happy and comfortable here, at home I was always frightened and scared…I had nobody to take care of me…I was scared of dying and rotting in the house…if that would happen everyone would come to take my money when I*

> *am dead. Here, I know someone is there for me" (Violet, Resident, Religious home)*
>
> *"When I entered this place, the most vulnerable and sad part of my life began. I cannot tell you who I am anymore or what I mean to say… I just feel they [the staff] have taken everything away from me. It is just as if you are at other's mercy, and you or your opinion does not even count …. Their word is the law." (Felix, Resident, Religious home)*

The above responses reinforce my ontological position that social reality is the social construction of social actors generating multiple and changing social realities (Blaikie, 2009; Denzin and Lincoln, 2000; Rubinstein, 1992; Strauss, 1990). I thus take an epistemological position that statistical patterns and correlations cannot be used in isolation to draw patterns in society; rather, it is necessary to find out the meanings which people give to their actions that lead to such patterns (Bryman, 2008; Denzin & Lincoln, 2000:3).

Besides my research question, other reasons also informed my choice of qualitative methodology for this study. Firstly, as Gillham (2000) asserts, in order to understand any phenomenon from the participants' perspectives, a qualitative methodology is most efficacious. Social science researchers such as Shaw and Gould (2001) assert that using qualitative research methods such as interviews and participant observation, adds positive value to social work research and practice. Studies by Bowling (2009), Holloway and Wheeler (2009), Hubbard *et al.* (2003) and Dewing (2002) have also shown that qualitative research methods are more appropriate and more effective than quantitative methods when researching older people in a social phenomenon, and thus allowing their voices to be heard in research.

Creswell (1998) identifies biography, case study, ethnography, grounded theory, and phenomenology as five major qualitative traditions of inquiry. After weighing up all these possibilities, on the basis of my research questions, the minimum control over the research environment, my focus on contemporary phenomenon within a natural real life context, and an inclination towards exploratory methodology, an ethnographic approach was chosen as the most appropriate research approach for my research. The intention was that this would help me to gain a deeper understanding of the older people, their relationships, their care, and above all, the

identities that are constructed and deconstructed as a result of the interactions within the setting (Yin, 2003:2, Stake, 2000:435).

Darlington and Scott (2002) have argued that it is important to see things as they happen in ethnographic research; to see people in their natural settings as they go about their lives. I used participant observation and interviews with residents and staff in the three care homes, making it possible for me to see things first-hand and to gain a deeper insight into verbal and non-verbal, observable and non-observable events. Doing so, I focused primarily on the residents' experiences and perspectives, following a person-centred approach to research, in order that their voices and stories could be heard directly.

3.4. The Research Process

This section will detail the different stages of my research process:

3.4.1. Field

As noted before, the research focussed on care homes in Goa, India. My familiarity with this part of India, being of Goan descent and having grown up and worked in this part of the country and in Goan care homes, initially informed my choice of the field. This choice was further prompted by a number of reasons already discussed in the introduction and the literature review chapter of this thesis.

In order to provide context and full descriptions of the experiences of the residents, it was important for me to first acquire a comprehensive understanding of the setting in Goa. This aim for a greater and wider depth to my data led me to conduct my fieldwork in three care homes in Goa rather than a single care home. The selection of the three care homes was done through a scoping study which is detailed in section 3.4.3. Conducting the study in three care homes was intended to bring an element of comparison to my study which is a fundamental aspect of cognition on which knowledge of social science is built (Bechhofer and Patterson, 2000). Comparisons control whether generalisations hold across the cases to which they apply (Sartori, 1994). Indeed, in choosing to observe and document, something other than an implicit comparison has been made. In my case, however, the intention was to explore whether conclusions reached in one context were applicable in another

different, but related, context, and, in the case of variations, to look into the possible reasons for them.

3.4.2. Time

My fieldwork was conducted from May to December 2011, during the second year of my PhD. Given my passion for the subject area, I anticipated my difficulty of being unable to leave the field. Hence, I had worked out a tentative framework and attempted to keep to it. This planning was crucial to the success of carrying out my fieldwork in the three care homes in eight months. As my fieldwork unfolded, it undertook the following pattern:

May-June: The first two months of my fieldwork were spent in establishing contacts and gathering preliminary information on the care homes in Goa through a scoping study. This phase included three stages. In stage one I surveyed the number of care homes in Goa, their names, location, and ownership. In the second stage I visited 37 care homes of the 52 care homes to ascertain further information on each and discuss access formalities. In the final phase, I selected three care homes and negotiated access in each of them. This selection is detailed in section 3.4.3.

July-September: The process of participant observation in the three care homes lasted three full months, involving a month in each home. The typical pattern that I set up and followed in each home was data collection for a period of 5 days a week working on different shifts, and covering all days of the week consecutively. At the end of the five day period I would go home for two days during which I would read and reflect on my field notes (On a daily basis, I took down head notes during shift hours – whenever possible – and wrote up details when I was off shift), and refresh myself for the next week. These moments of stepping away from the fieldwork and sifting through my recorded data helped me to distance myself emotionally from the field and its impressions.

At the start of this period, I used the word ‘explore’ and ‘drift’ in my field notes to describe my involvement, with the idea of going with the flow of events in the care home. At this time I needed to get to know the residents and the staff, to give a clear message about my purpose, and to be around with different groups of people at different times (Geertz, 1998). In the later stages of my field work – towards the end of the month – I have used words like ‘immerse’ to describe my involvement.

The difference in expressions in my field notes evinces how spending time in the field aided the collection of my data. At the end of this period I was able to develop an interview schedule for use with the residents in my next stage.

October-November: During this period I interviewed 24 residents, 12 staff and 4 managers across all three homes. Interviews gave research participants (residents, staff and management) the opportunity of expressing their views freely and allowed me the opportunity to explore their views in greater depth (Esterberg, 2002).

December: I made brief visits to the three care homes to let my research participants know I was leaving but would be in touch later.

Time is of two kinds – temporal, that is, past, present, and future; and categorical, that is, the order of occurrence of events. In this accord, time, in my research, was an integral part of my research participants' life and hence of my analysis. Thus, time, in itself was an actor, in the process of my field work and data analysis. The residents speculated about their own lives in relation to their residential career in the care home. The residents and I both attempted to make sense of their experiences in the care home and in so doing often provided a storyline, "repeating threads that they could trace through the plot, ordering their present situations in relation to their past, pointing out ironies and echoes, and reiterating comments on different occasions" (Jeffery and Jeffery, 1996:31). Thus, time was a meeting point of the residents' perceptions of their experiences in care homes as a career having four phases: pre-entry, entry, post entry and exit, with my understanding.

3.4.3. Research Methods

Qualitative research methods, combining participant observation and interviews, are widely believed to be suitable for challenging the power relation between researchers and the researched. It rejects claims of being value free and seeks to establish a commonality of experience (McDowell, 1992). Through the processes of listening, empathising, and validating, shared experiences and connections are established between the researcher and the researched. It is the reciprocity and intersubjectivity that characterises such research (Oakley, 1991). Thus, both participant observation and interviews were used in an attempt to answer my research questions. However, as noted above, before venturing into the care

homes, background research was conducted by reviewing literature and conducting a scoping study.

Documents

Literature on ageing and care homes in India, though limited, needed to be accessed to locate my specific enquiry within the broader contextual area of institutional care and ageing. Thus, I began by looking at published literature in the University of Edinburgh library (online and hard copies) for studies carried out in the same area (institutional care, care homes, older people, ageing and related issues) by other researchers internationally and locally. Most of these studies were either quantitative research concentrating on the condition of the care homes or were limited to care homes in developed countries such as the United States of America (USA), Canada, Australia, the United Kingdom (UK) and other parts of Europe. They were useful in helping me to conceive a background to my own study and to identify the gaps that I have already noted in the previous chapter.

In relation to studies and statistics on ageing and institutional care in Goa, with the exception of a couple of published materials, I relied on official documents by Government bodies (Goa Government, Statistics and Planning, Provedoria [Social Assistance] and Social Welfare), reports conducted by NGOs (Research Institute for Women, Sangath, HelpAge India and Forum for Senior Citizens of India [Goa], and articles in local newspapers (OHeraldO, Navhind Times, Times of India [Goa Edition], Gomantak Times). These helped me in contextualising my research further. The demographic information from the Government and NGOs pertained to the number of older people in Goa, the number of care homes in Goa, the socio-economic profile of older people in care homes, and different schemes, facilities and services available to older people. The newspapers likewise carried articles on the quality of life in care homes (see appendix 1). All this helped me better to understand my research area.

Furthermore, the care homes had individual charters, brochures or handbooks relating to their values, mission, mandates, culture, policies, procedures, and other information which was handed to me during the scoping study. This information was essential to get a sense of where to locate and how to draw comparisons

(commonalities and differences) between the three care homes which I would be selecting and studying.

Scoping study

Due to the lack of published data on care homes in Goa, I conducted a scoping study. This study served three purposes: firstly, to identify the extent, nature, and range of care homes in Goa; secondly, to aid the selection of these homes; and thirdly, to discuss access negotiations with the selected homes. The majority of old persons in India fall between the ages of 60 to 80 (HelpAge India, 2009). Gerontologists divide older populations into groups for the purpose of analysis: the young old and the old old, with 75-80 as the dividing line (Haber, 2010). They claim that very few statements can be made about the population over 60 in general as the old are different physically and cognitively and hence their concerns are different and varied. The residents in care homes in Goa by and large are between the ages of 60 and 80 years. Keeping the above in mind and for various methodological, practical and ethical reasons, I have focused on the young older population, that is, older people between the age groups of 60-80.

Identifying the care homes

The first phase of the scoping study was spent in gathering information about as many care homes in Goa as possible: name, location, ownership and contact details and compiling a list. To begin with, different Government departments including Provedoria (Social Assistance) and Social Welfare were consulted. I also visited NGOs namely Sangath, HelpAge India and Forum for Senior Citizens of India (Goa). With the information from all the above sources, a list of 52 care homes in Goa was completed. Broader criteria cited below were used to narrow down the scoping study in the first instance:

The sources that I relied on classify care homes in Goa into three major categories: (1) Government, (2) Religious and (3) Private. My decision to select three care homes was based on these pre-established categories. In the first category there were 9, the second had 33 and the third had 10.

Goa is divided into five districts for administrative purposes All of the the care homes except four were situated in three districts, that is, Tiswadi, Bardez and

Salcete.[5] Here again, 40 of the 52 homes were situated in North Goa. Being based in North Goa and given the issues of connectivity and access, I decided to limit my study to homes in North Goa.[6] This helped to narrow down the selection as well as making the fieldwork more manageable.

The number of single sex care homes was higher than mixed homes. Of the 52, 24 catered only for women and 7 only for men. During the scoping study a number of reasons were found to be responsible for this. Firstly, staff found it easier to deal with residents belonging to their own gender. Secondly, men were found to be more violent than women, hence men in many cases were refused admission, which helps to explain why there were more women-only homes as noted by managers during the scoping study. Thirdly, single-sex homes were preferred by staff as a strategy to avoid unacceptable relationships between men and women above 60.[7] An important aim of my research was to observe the relationships constructed and the meanings given to them. A holistic view on relationships would be incomplete without having both genders included in my study. This thus served as another important criterion for selection (though all the homes were included in the scoping study). This may bring in methodological questions: could findings from care homes catering for both sexes be extended to single-sex care homes? Would including single sex care homes give me a different perspective on institutional care? However, without rejecting the claim that including single sex care homes within the realm of my fieldwork would have potential benefits for my study it was a decision which I made with the aim of minimizing the differences between care homes for a comparison to be drawn between them. This is something which I would definitely like to take up for further research.

[5] these geographical areas have a large expatriate population (Research Institute for Women, 2002)

[6] I however visited the care homes in South Goa too, in order to factor any significant characteristics that these homes may have. However, based on the scoping study questionnaire results they shared similar characteristics with their counterparts in North Goa.

[7] An intimate relationship between men and women (except between spouses) is taboo in the local culture.

Finally, I decided to select homes which had been operational for at least 5 years and had no plans to close down.[8] This length of time provided an element of stability to the home being researched.

Selection of the three care homes

With these broader selection criteria I began visiting care homes in Goa, including the homes in which I had volunteered previously. Including these homes can be challenged on grounds of familiarity but I had stopped volunteering there five years before. Besides, during this time there had been changes in the management, staff and residents' population, hence, any past familiarity with them would also have altered. Thus, there were certain facets that were not familiar to me. Nevertheless, at the same time I could not completely rule out familiarity. I was aware of the fact that previous volunteering and familiarity with the place could bring in prejudices and research biases. In the same way, some research participants could have an 'insider view' of me. This negotiation could affect the data gathered as it would be different from my role (outsider) in the other homes. Admittedly, the temptation to interpret the bias and familiarities with issues from my past volunteering would always be there even in an unfamiliar home. At the same time, the residents' view of me as a researcher in other homes could not be guaranteed. As my fieldwork data showed, I was seen as a member of staff, as a social worker, or as a friend by many residents in the unfamiliar homes. Thus, I had to accept the reality of my familiarity, but also to be reflexive while gathering the data. On similar lines, my inclusion of these homes in the scoping study was a step towards detaching myself from the volunteer's role and giving these institutions a status similar to that of the other homes.

During the second phase of my scoping study, I visited 37 homes in total after making an initial contact by telephone or in person and asking for consent to visit them (23 Religious, 9 Government and 5 Private). Contact with the remaining 15 homes was impossible due to a negative response from management or the homes could not be contacted using the contact information which I had. On visiting each of

[8] The reasons for likely closure in the near future included lack of staff, lack of Government funding, or the moving of the trust or organisation to a different setting. It would be interesting to document the reaction of the residents to this move. However, for practical reasons my research could not address this issue.

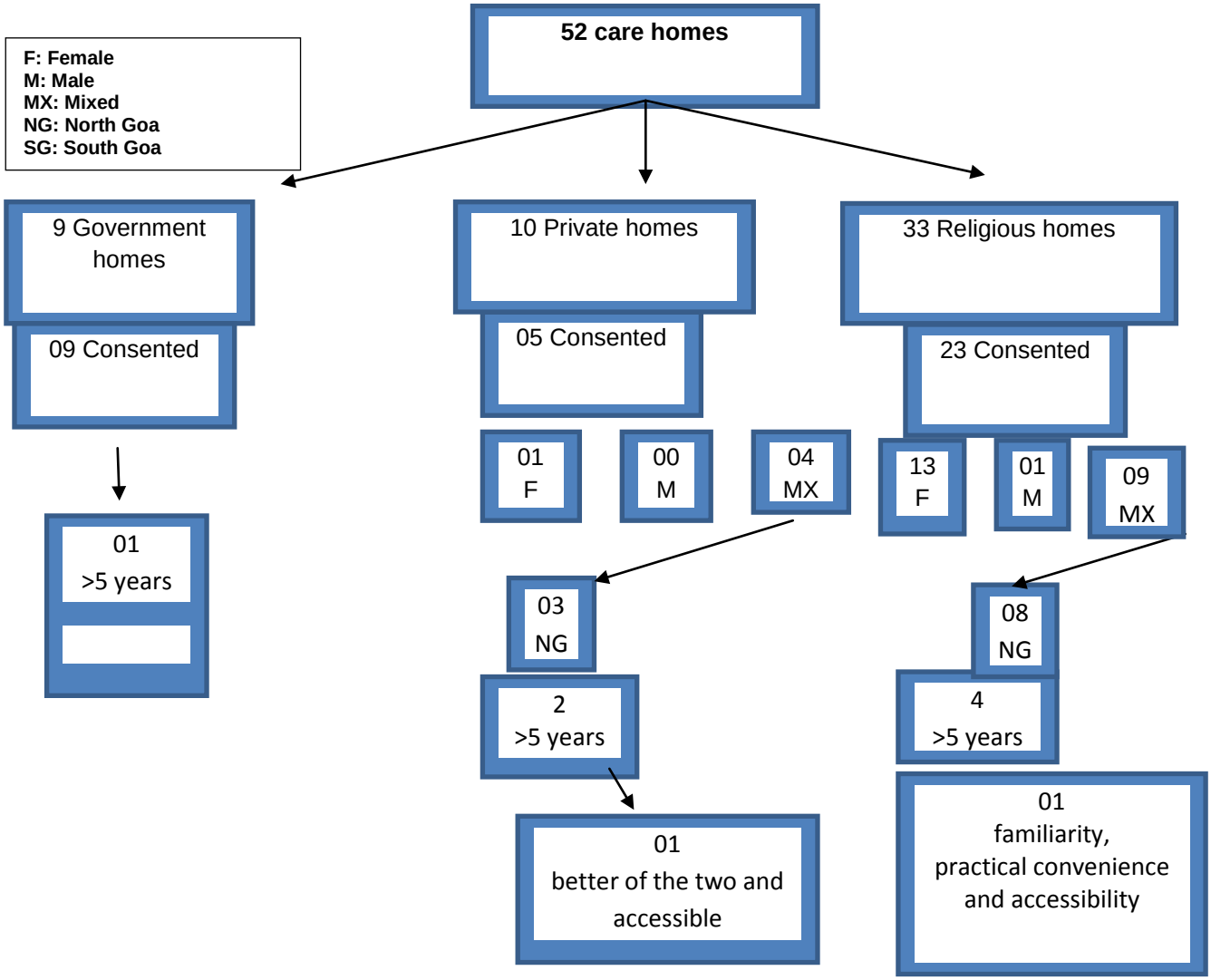
the 37 homes, I explained my research, its aims and objectives and submitted a formal permission letter from the University (see appendix 2). I then spent 2 to 4 hours in each home; talking to the management, touring the home and filling in the questionnaire (see appendix 3). The major themes included were:

- History and motivation (ideology)
- Structure and management
- Services provided
- Payment structure (Finance)
- Entry requirement, entry process, exit,
- Type of accommodation
- Characteristics of people in the care home (number of individuals in the home, age, sex, method of payment, number of years spent)
- Idea of a typical day
- Shifts for volunteers

At the end of the second phase, the information gathered from these field visits were charted onto an Excel spread sheet, with different worksheets for each category. This made it easier to see institutions both individually and against the others and thus narrow down on the ones selected. (See appendix 4)

The selection of the three homes – Private, Government and Religious took place in the final phase. Figure 3.1 shows the selection process. The broad criteria for narrowing down on the selection were the type of home, consent to participate in the study, locale, composition and length of the home's existence. Besides, practical and accessibility criteria were also used in the selection. This will be detailed individually for each of the homes in the discussions following figure 3.1.

Figure 3.1: Selection of the three care homes



The home which I selected from among the 5 private homes had functioned for about 20 years. HelpAge India (Goa office) indicated that it was among the best Private homes in Goa. The payment options were similar to that of the religious homes (in some cases lower) but higher than the Government home. Thus based on both the quantitative data gathered and the qualitative observations made, I selected this home. The selection of the Government home was made using similar criterions. In selecting the Religious home, I began by using the broader criteria to start with; I decided to include only homes which had both sexes i.e. 9 of 23, located in North Goa – all 9 and, were functional for 10 years. This narrowed the homes to 4. Further, practical and logistic reasons drove my selection of the Religious home. I selected

the home that I had volunteered in previously. At the same time this home was located close to my home town. In this way I could minimise the difficulties of travelling long distances during heavy monsoons (during which I began my fieldwork). Finally my selection for this home was based on the idea derived from the Berthoff study (described in Cochran-Smith and Lytle, 1993). The idea highlighting this part of my research could be expressed as revisiting the old to inform the new.

Negotiating access in the three care homes

During my scoping study, I spoke to the managers of all 37 homes about the logistics and possibility of me staying there during my field work. After selecting the three homes, I formally obtained permission from the manager to stay and conduct my field work in the care home. In all the three care homes, the managers instantly gave their approval to let me stay and work there for as long as I needed.

Participant Observation

I adopted this method because I needed a first-hand view of the situation in order to understand the older peoples' perceptions and to be able to interpret the meanings they gave to their everyday experiences in the care home. Observing older people in their natural setting, and communicating directly with them, provided me with the much needed opportunity to make them feel at ease and confident about relaying their experiences and understandings of their daily lives (Hammersley, 1998). This method also allowed me to see things through their eyes. Ultimately, participant observation of life in the care homes provided me with a deeper understanding of how the homes operated on a day-to-day basis. May (1993) has pointed out that relatively long term multi-dimensional relations which the participant observer forms in the field usually lead to a better understanding of the social scene. Through this, the researcher not only becomes an instrument for data collection, but also a part of the social world where the individuals are producing and interpreting new meanings. Researchers are also able to observe the dominant culture of a group, roles within this culture, and how members reproduce or resist that culture (Kleinman *et al.*, 1994). Individuals are also sometimes constrained by the meanings of the world they live in, and generally this is not possible to understand unless observation is used (Kleinman *et al.*, 1994). Moreover, participant observation

can provide access to matters which participants are unwilling or unable to talk about during the interviews, and can provide a better contextual setting of the institution (Patton, 1990). The choice of participant observation was also a matter of personal preference for me. Given the uniquely personal and complex nature of ageing, a highly structured design was seen as inappropriate (da Gama, 2005). Flexibility and naturalistic design was needed as research tools that could be modified to avoid fatigue and stress, considering the vulnerability of the residents.

As a participant observer, I began by covering three shifts (8 am to 5 pm, 12.30 pm to 9 pm and 9 pm to 8 am) for a month in each home. Observations were conducted five days a week on different shifts in each setting. However, as it turned out, I spent more time in the first two shifts than the third. The night shift basically entailed spending three hours in the night and two hours in the morning.

The observation was first carried out in the Religious home (July 2011), then I moved on to the Government home (August 2011), and finally ended in the Private home (September 2011). Familiarity, physical proximity to the home and the weather conditions in Goa at that point prompted my decision to begin with the Religious home.[9] Familiarity provided a comfort zone to explore the researcher in me, which I could then carry forward to the other homes. The Religious home had past familiarity associated with it (as a volunteer five years before I began my field work). At the same time it had the freshness of the other two homes: a new manager, new staff (except two) and new residents (except for five, the other residents had died or had been moved).

The familiarity element as it unfolded posed both a challenge and strength. I was a participant observer with my past volunteering experience. On the one hand, I was allowed to ask personal questions and probe, allowing the individuals in the study to let down their guard and permitting me to enter as an insider who would be informed of their personal and very private experiences. On the other hand this role raised anxious reactions from a couple of residents who chose to withdraw from talking to me. This may have been because of dilemmas in the residents' minds about how the data might be used, even though I tried to reassure them about the

[9] Goa witnesses the bad monsoon rains in June, July and August 2011. Travelling long distances to reach the other homes were more likely to be met with transport problems and flooding obstacles.

confidentiality and anonymity of their identity and information. Another problem of starting as an 'insider' was that the participants (resident/staff) insisted on my full participation. Often a whole shift would be taken up with routine daily tasks which made observation difficult. Eventually, I had to negotiate a change of status to that of participant observer/researcher without too much of a personal upheaval or disruption to the life of the home. A poignant observation from my field-notes clarifies this:

> *'The manager had handed me annual reports of the last five years. I had decided to read these after lunch. Just after lunch one of the staff 'ordered' me to help with washing the dishes. I politely refused and explained that I needed to read the reports and make notes for my research as I was pressed for time to finish my field work. She did not say anything but pulled a face. She might have been a bit upset and this might affect her behaviour towards me in the future, but it was important to put my point across' (Fieldnotes, Religious home, August 2011)*

A volunteer is expected to perform most of the tasks assigned; hence my reaction to instances like the above helped to make my position as a researcher more prominent. In fact, the analysis of files and reports during field work helped me to extract myself from the day to day activities of the home and at the same time make my role as a researcher more obvious.

In the Government home, my transition from 'outsider' to 'participant' was initiated by giving gifts to residents. This was never my deliberate strategy as I was afraid of these donations being seen as incentives, affecting the validity and ethical stand of my research, but it was something which unfolded at the scene. In a way, I perceived these gestures of mine as small gestures of gratitude for people's time and cooperation. The residents, particularly women, asked me to bring in religious artefacts, stationery and sometimes food stuffs to which I obliged.[10] Men's requests were directed towards smuggling in alcohol and cigarettes which in my view could put their health at risk and therefore I did not oblige. Hence the ease of transition was felt more among the female residents than with the male. At the same time, men lived in separate large dormitories which were badly lit. This environment inhibited

[10] Giving gifts (except monetary) was not prohibited in the home. Thus the rules of the homes were not broken.

me from visiting the dormitories regularly probably because of the culture I come from and my personal reservations. Hence, my observations of the men were mostly restricted to communal areas or with the staff's presence in the dormitories. The dormitories were spaces where resistance against the management and staff were conceived. Often in the ladies' dormitory, informal discussions were held around beds. The dormitories were also places where direct resistance against staff and other residents took place. These kinds of observations I may have missed in men's dormitories (though direct resistance against staff has been covered). I attempted to raise this issue in interviews with the men, and though they highlighted instances of individual resistance, the issue of collective resistance was never addressed by them despite my probing.

Conducting participant observation in the Private home was more complicated due to the design of the building (see chapter 4 page 84). It meant that I was usually excluded from the private areas of the residents' activities. This difficulty, to a certain extent, was initiated by the manager of this home who introduced me to all as a volunteer cum intern who was there to observe, talk and learn. This meant that the staff saw me as their junior and felt a level of pride in being capable of teaching me. However, my role as a volunteer remained intact as far as the residents were concerned. This meant that I gained access to bedroom areas. The main problem here again was that I had to keep reiterating my position as a researcher.

In summary, the independent researcher definition was difficult for my participants to contemplate in all the three homes. However, over time, particularly towards the end of my data collection in these homes, I tried to negotiate this change though the distance always remained.

> *I accompanied Kareena (staff) to serve lunch to Mary who I had met before. At this point she asked Kareena what this 'specimen', meaning me, is doing there. Kareena starts laughing and told her I'm her boss. She did not comment on this, but pulled a face. Kareena said to me: "Of course she doesn't believe me." I answered that she is right. This situation was not only particularly embarrassing for me but also pointed to the distance there was between me and the residents' world. (Field notes, Government home, September 2011)*

Throughout my participant observation in the three care homes, I adopted a hanging around strategy for most of the period (Geertz, 1998). This meant that I participated in their daily lives. I participated in their activities and those of the staff, engaged in informal conversations with the residents, was around in the common spaces when they were not actively engaged in activities, and visited them in their room or dormitories. I was generally around the whole time. Moreover, much of my observational data came from informal conversations with the residents and observations of them. I observed their daily patterns of activity. I was aware of their social interactions and behaviours. I observed their various conversations with the staff and with other residents in order to examine the identities and selves that they portrayed. I also observed the staff's interactions and activities with residents so as to determine how specific routines and regulations controlled the residents. At the same time, my observations were extended to various kinds of agency manifested by the residents and the staff's reactions to them. In addition, I examined residents' use of their agency – facial features, gestural communication, or vocal rebellions – to understand how their agency was a part of their daily experience.

Interviews

Following the participant observation, I returned to conduct interviews in all three homes. This provided an opportunity to revisit the homes and explore gaps in the data (Rubin and Rubin, 1995: 76-83). It also provided the residents with opportunities, if they so desired, to talk about their experiences in the care home. As the main objective of the research was to map the perception and understandings of the residents' experiences in care homes, the interviews were meant to generate data in terms of the interviewees' own accounts, understanding of discourses, and meanings which, combined with the conclusions from participant observation, would form the basis of insightful ethnography. The data that the interviews generated were meant to be important in answering questions about the residents' perceptions of their career in the care home. By contrasting and combining them with the participant observation they could form the basis of a rounded and nuanced data to answer the research question.

The respondents were chosen on the basis of the observations made during the previous stage. Given the nature of the research, a purposive sampling technique was utilised, that is, I made sure that the respondents had been living in the care home for a minimum of five years, that they were logical and coherent in their interactions (the capacity of the residents was confirmed with management and staff), that they included different categories of residents (gender, age groups, education) and that they consented to speak with me. This was more to gather different experiences than being representative of the particular population. In-depth interviews with 8 residents, 4 staff and the manager (2 managerial staff – one manager and one assistant manager – in the case of the Government home) took place in each home. The in-depth interviews were guided by a flexible schedule which was developed by relying on the themes emerging from participant observation (see appendix 5). These interviews were tape-recorded for later transcription. The interviews were conducted in Konkani and English with occasional phrases in Portuguese. Being fluent in English and Konkani and having a working knowledge of Portuguese I was able to translate the interviews myself during transcription. However, some regional words and sentences have been retained to avoid losing the regional flavour in the analysis.

The interview guides were flexible in structure and were altered depending on the suitability for the respondents. Most respondents spoke at length. However, this sometimes made it difficult to keep them focussed on the interview schedule. This was thus very time consuming and at times interviews would continue with periodic interruptions, such as lunch, a nap and the administration of medication. This affected data collection as it was difficult to get the link back to the previous discussion. At the same time the transcriptions pointed to the ability of two people to talk about a particular subject without even mentioning it. What from memory was a perfectly coherent conversation looked quite ridiculous when transcribed. My interviews with staff also had the same pattern. However, though the majority of the staff were enthusiastic about the interviews, there were some who discreetly refused. They gave reasons of being busy, tired, and new to the job to avoid the interview. This may be also because they were unsure of how the information might be used

even though I had assured them about the confidentiality and anonymity of their interviews.

All the successful interviews conducted with the residents had a career element to it: coming into the home, experiences in the home and their perceptions regarding their exit from the home. While narrating their experiences there were residents who cried. At this point I made sure to instantly stop the interview and apologised for making them reminisce about memories which seemed painful for them. However, generally they wanted to continue talking about it as some of them claimed that it was the first time they were able to talk about these issues. Hence, in a way, the residents possibly found the interviews therapeutic, particularly in reminiscing about their past. These interviews, however, at time proved intense for me and therefore were a slight strain on me. Still, this is not to discount the strain on the residents themselves who quickly become tired (hence interviews for some residents had to be spread over two or three separate sessions sometimes lasting a couple of days). Nevertheless, the above experience, coupled with the moving stories I listened to, and the emotional drain on myself and the residents necessitated spacing the interviews and interspersing them with other activities to help me to prepare myself for these intensive sessions.

According to Janesick (2001; 50-51)

> "fixed moments, some planned interviews, scheduled observation, document reviews and at the same time within the parameters of these events the researcher needs to improvise to capture the critical events or moments in the lives of the participants".

My study also progressed along these lines. I reached the field with extensive plans about the course to be pursued. Some of these plans met with success and some with failure. What was crucial was to constantly think of the choices available and being sensitive to the events and people around me, to improvise the methods that I had learnt to suit the current situation and draw out the richest details without causing much pain to the respondents. Although I ran into difficulties at some points, which persisted throughout the course of my fieldwork and in my final analysis, through a combination of success and failure I was able to gather sufficient data to

satisfactorily answer my research questions (more on difficulties in section 3.6. on challenges).

3.4.4. Recording data

General techniques such as observation, listening, conversation and reflection were employed in the homes for data generation. Field notes were used to record the data. A reflexive diary was also kept with my insights, interpretations, and relationships with the residents, feelings about the care homes and residents, and anything else that was not included in the field notes.

During the long hours of participant observation in the care home I carried a small notepad, in which I jotted down the events and conversations that occurred in point format. The problem that I faced here was transcribing the points into longer detailed field notes which could be done only at the end of the day or when I was alone. I generally remembered the conversations that were directly related to my enquiry. Still, there were also topics which I found difficult to distinctly recollect in a detailed manner. On these occasions I went back and checked with the respondents for this. This problem persisted throughout my fieldwork although I had become more accustomed to it at a later stage. Many of the things I missed out from recording in my notes, I suspect still formed part of my subconscious knowledge and probably helped me to understand the available data better.

Field notes from a typical shift consisted of around 1000 words. The early participant observation at the Religious home provided a chronological account of events in the home. The following extract from the field notes shows the changing style of the recording throughout the research period:

> *01.07.2011. First day. Arrived at 8.00 am, three residents were sitting on the balcony just staring into space. It was very quiet. Reggie stood at the door with the paper. A couple of residents were seated in the common sitting area. The television was off but all were looking in the direction of the television. There was very little contact among them. They were all capable of chatting but were resigned and completely uninterested in any conversation. The active residents were cutting vegetables in the dining area I went to greet them. Throughout the day there was no therapy, or activity except eating, an hour of television, and prayers. There were very few staff. I find it distressing and difficult talking to residents. For every effort to do so was met with*

> *absence of reciprocation. I felt very conscious, like being a bad anchor on a reality show… I suppose this will pass. (Fieldnotes, Religious home, July, 2011)*

In this first extract the somewhat laden judgements are apparent. After a week I decided to write an account of some of my feelings at the home. This was intended as a means by which I could exercise some of those judgements:

> *'My first day was, as expected, a shock and as far as I can remember I experienced a kind of superior feeling that I would never behave like the staff there. I found them rather coarse and certainly felt they did not treat the residents with the dignity (mann) that I saw as important…The onus for improvement fell very much with the care staff. I tend to see the residents as helpless victims. I also felt that so much time was taken up with staff work that it overrides, very often, any consideration for the residents. The work ethos, for instance, required that a care attendant was seen to be working and working was defined very much in terms of production. Therefore, sitting and talking to a resident was seen as not productive and not work, whereas talking to another staff member was not seen negatively. The residents were very withdrawn from the activities of the home, they behaved in a mechanical manner in following the timings and rules that the home had suggested' (Field notes, Religious home, July 2011).*

This early period of note taking was both enhanced and dogged by a prior knowledge of the situation. As the research period lengthened and my role as researcher became more established, the notes became less anecdotal and more of the 'typical incident' variety and more chronological and more 'objective'. For instance, there is quite a difference in style between the initial record and that of the later:

> ***Observation:*** *There followed an incident with Carmen as she was walking back to her dormitory with her lunch plate in hand. She has arthritis. So she could not walk fast, and she kept telling the staff she needed to go to the toilet. I, with the help of another staff, helped her with her plate and led her to the toilet. We got there and before she could enter the toilet, she did it all over the floor. The staff members were annoyed about it. They eventually mopped up the mess. Violet kept apologising*
>
> ***Interpretation:*** *It is not particularly relevant that we were annoyed with her except that this indicates a mild form of what the staff members have to put up with all the time. The apology by Carmen is a manifestation of how helpless she*

was feeling. How can you negotiate between these feelings? (Field notes, Government home, August 2011).

It is clear from the above, that interpretation and, in a way, simple data analysis took place simultaneously with my recording. An important point to note here is that by the time I reached the second home the note taking process had a more established style. The notes contained categories (e.g. 'the work ethos' and 'resident's reaction') and analytic comments about why situations were as they were. I also recorded the 'typical day' as I experienced it during the three months. A small sketch of each of the residents as I had understood them as a volunteer was added in my field notes.

Beatty (1999) points out that most researchers find it difficult to demarcate the knowledge gathered from talking to people and that which they absorbed through taking part. Hence, I had to maintain a constant awareness of separating the articulated and unarticulated parts of the fieldwork. While this was not always possible while writing down the day's field notes, reading and re-reading it a couple of times critically made it possible to identify the elements which had merged and then to separate them. This re-reading of the notes also gave a certain amount of reflexivity about the data.

In the case of interviews, recording via an audio recorder was the norm (with prior consent of the interviewees). Audio recording enabled me to capture the whole interview, including tiny nuances and silences. In addition, I always took brief notes. This served as a backup in case anything went wrong with the recording or there was too much background noise. It also helped to make a note of the body language and facial cues of the interviewees. All the respondents consented to tape recording of the interview. Through a combination of recording and note taking I documented my fieldwork. Another point to mention here is that I also took some photographs in the three care homes throughout my fieldwork to capture the setting, with consent from the residents, the staff and the management.

Interference and influence on data

A researcher's actions may interfere or influence the data collected. In this section I will give a few examples of how my actions could, and to what degree, have, interfered and influenced the data.

In an exchange with one of the female staff, as recorded in my field notes, it was noted that:

> *‘ Kareena (staff) was teasing Nilu (resident) and asking her where her son was. (Nilu’s son has abandoned her after admitting her in the home, he has not visited her for the last six years, she however thinks he is another male carer Prem) Nilu said he was ‘over there’, pointing to Prem. I said to Kareena that she was compounding her confusion and that she should not do it. Kareena told me it’s just for fun and I was overreacting…but she did stop’ (Field notes, Government home, August 2011).*

This was blatant and direct interference. This interference might have made Kareena cautious of her behaviour in my presence in the future, which in turn might have affected my data. However, the ethical challenges of not interfering in some instances like this were greater than the methodological problems of doing so. A less direct influence is illustrated in the following extract.

> *‘There was some talk about how Goan people should stay in Goa instead of moving abroad in search of better prospects. Someone said not to say that in front of me since I was studying abroad’ (Field notes, Private home, September 2011).*

This particular influence was more insidious and probably did not directly affect my data. However, this kind of personal influence on my data might have affected the staff’s perception of me, their relationship with me, and their reaction to my presence. My identity of being a Goan studying abroad might have further affected the data I gathered. Nevertheless, the underlying relations between changing socio-economic demographics and the experiences of older people in care homes were absent in my conversations with many staff even when probed.

In many instances, the interview provided a therapeutic forum for not just some residents but also the staff at the homes. The healing qualities present in listening and talking is a known fact. Comments similar to below were often made after interviews:

> *“I am not sure whether I should have said that, but it is a huge burden off me” (Leena, Resident, Religious home)*

> *“I am glad you listened to me; it has been a while since someone did that” (Laxmi, Resident, Government home)*

> *"Another particular note to be made is that many interviewees tended to use the interview as a therapeutic exercise and would often at the end say that they had enjoyed the discussion. I thought of this as a casual remark until I began transcription where I noted that interviewees often 'got things off their chest' and focussed on particular incidents that had upset them…I began to feel that the presence alone of a researcher, irrespective of findings, is a shot in the arm for much neglected feelings. At the same time I am not sure how to deal with the trust the respondents had put in me. Will I be using their most private details as a path to gain an academic award for myself ☹' (Personal Reflections, November 2011).*

However there were two issues I needed to be cautious about. The first and biggest challenge was to be cautious of the resident's mental state as they are very vulnerable; every little recollection of bad memory had the potential to upset them. This could raise certain ethical issues. Hence, I was very cautious about this throughout my fieldwork process, particularly during the interviews. Even if interviews got depressing I always tried to end on a positive note. In fact, in many cases we sang a local folk song together at the end or simply hugged each other. For example:

> *The most troubling incident happened today when I was interviewing Jaunita. She was getting very tearful over the interview remembering her family, so I thought I would ask her something more general. So I casually asked her: "what you want to do tomorrow?" She at once replied "I want to die, I am fed up with this life" I was overwhelmed at this juncture and just hugged her. This infringed on the researcher side in me but I continued holding her for a while till she was able to compose herself. I stopped the interview and then recited a local folk song to her which she joined in. It was lunch time at this point; so I got her lunch and we spoke about the weather. Eventually, she had overcome her grief but I was still overwhelmed and thinking whether I can use these stories and emotions for my research. (Field notes, Government home, August 2011).*

The second issue is related to my role of a problem solver that started getting prominent towards the later part of my fieldwork.[11] "Knowing something about

[11] When I realised this, I consciously began to stop it by clarifying my position in the home.

problems in care facilities and the like creates a responsibility to do something to improve daily living for residents and their care providers" (Lyman, 1994: 18). Both the staff and residents approached me to help take their woes to the next higher management level. This showed their trust in me but at the same time burdened me with a responsibility:

> *'In the Religious home, two staff tried to use me to advocate their problems of understaffing, and their concern about the incapability of some staff, to the manager. They hoped that I would be able to do something about the situation as the manager would not listen to them.' (Field notes, Religious home, July 2011).*

This issue of taking sides somehow remained unresolved. Further discussion on this will take place in the challenges section of this chapter (see page 80 and 81).

3.4.5. Leaving

Leaving the field was a difficult process. The homes had become a place where deep feelings of anger, compassion and resentment, to name but a few had been expressed between the staff, the residents and me. My visits were often waited for. If I failed to turn up in time, both staff and residents would express their concern. There was also a lot of laughter and cheer as well as some tears that we had shared together. As a whole, intimate daily contact with the staff and the residents led to feelings of real friendship, so it was hardly surprising that leaving the homes was difficult. I decided to announce a date upon which I would be leaving. This date was for administrative convenience. In fact, I started my leaving process by spending less time day by day at the home. At this juncture I was asked by a resident, "So you too are like those people who come and take our interviews and then go away and we never see them or hear from them again?" I said nothing in defence but left with a promise to stay in touch.

When I reflected on these eight months, I realised that the staff population in the three homes had remained virtually unchanged (except for transfers in the Government home) but the resident population had altered. Recalling the residents who died made me realise the transitory nature of care work and admire the ability of the staff to constantly adapt to new circumstances as well as cope with loss. In much the same way and perhaps more admirable is the coping strategy of the residents.

This will be dealt with in detail in my analysis chapters. My first return to the Religious home for the interview phase left me more distressed than I had imagined since a resident had died. Another important point here is that I had assumed somewhat pompously, that my presence and then lack of it would have left its mark on the home. Nothing of that sort had occurred. My lack of impact on the home and the people within it was made all the more apparent by the fact that when I returned to say goodbye to them towards the end of December before returning to the UK, very few residents and staff members were welcoming; others were busy in their 'own world'. This for me was also seen as an evidence of their coping strategy.

3.4.6. Transcription and analysis

Most of the field notes were written down during the time of the fieldwork itself. I tried as far as possible to finish each day's notes on the day itself when the events were still fresh in the mind. The interview transcription, in contrast, took more time to complete. Since the 40 interviews were done over a two month period, each of which lasted between 1 to 2 hours in total (this timespan was spread over an entire day or sometimes even two days), it became difficult to finish the transcription in the field because of the limited time in the field and the strain that the transcription was having on me. The interviews were conducted in English and Konkani and – since I had adequate proficiency in both – I translated and transcribed the interviews simultaneously to save time. All the interviews were transcribed in full but it was not a verbatim transcription. My interview notes, which focused on the body language and facial expressions, aided this process. The transcription process continued in the UK, and was completed in March 2012. The original recordings are preserved in a password secured laptop computer and were referred to check whether my impressions were correct when writing my analysis chapters.

As qualitative studies involve a voluminous amount of data, organizing or managing raw data is important for easy retrieval and for effective analysis. The raw data for this study were stored in the form of large volumes of field notes and 40 interview transcripts in my computer. Computer Assisted Data Analysis Software (CAQDAS), ATLAS, was used to code, categorise and process the qualitative data collected. As a first step the data were familiarised through meaningful reading and re-reading before starting the process of data analysis.

The process of analysis began with data coding. According to Charmaz, (1995) coding is the process of defining what the raw data being analysed are all about. It involves identifying the passages of text under some theoretical or descriptive labels (Gibbs, 2007). There are different types of coding available for data analysis and it depends on the kind of research framework and nature of availability of data at hand (Lewis and Silver, 2007). Miles and Huberman (1994), for example, describe the deductive method of coding under three categories: descriptive, interpretive and pattern. By contrast, Glaser and Strauss (1967) categorise coding under the inductive method into three types: open, axial and selective. In general it is widely accepted that analysis always involves the combination of inductive and deductive coding, which means, top-down and bottom-up analyses. This study used thematic analysis for data analysis. Bryman (2008) observes that a theme in the thematic analysis is more or less the same as a code for some writers, whereas for others it transcends any one code and is built up out of a group of codes. I drew my codes out from more analytical themes built around the research questions. Some examples of the kinds of codes used were 'institutional controls', 'agency' and 'losses'. Each code included various other sub-codes, such as, 'group living', 'autonomy', and 'vocal rebellion'. The data in this study were then analysed at two levels. At the first level, the relationships between different codes were analysed on a case by case basis. At the second level, the cases were clubbed together and compared with other groups (between private/religious/Government). The emergent themes found a common ground in all the three care homes.

Analysis, thus, consisted of exploring how the emergent themes formed a narrative answering the main research question. An overarching theme that linked the different emerging themes was the career of a resident in a care home beginning with pre-entry phase and ending with his perceived form of exit from the care home. There were four main themes which emerged from this process of analysis. These included loss, dependency, agency, and departure. The data were used to explore these four concepts and to link them together in an intelligible pattern. I used existing theoretical models that are relevant in explaining and exploring the data, and then placed the data in a broader framework of institutional living as discussed in the previous chapter. Grounded theory played an important role here. Strauss and Corbin

(1994) advocate the use of grounded theory that arises not from the academic world but from field data in qualitative analysis. Such theory is connected to evidence not through deduction but through active engagement. Dey (2004) further argues that grounded theory completely rejects deductive analysis thus constraining the usage of theoretical and conceptual resources that social enquiry already possesses. Without carrying it to an extreme, grounded theory proved to be extremely valuable for my research. While the preliminary ideas are derived from the prevailing literature, checking the data against those pre-existing conceptions not only grounds the research in social reality but also contributes to a deeper understanding.

3.5. Ethical Issues

Ethical considerations are particularly crucial in research with older people, who are considered a vulnerable section of society (Lyman, 1994). The concerns of informed consent, voluntary participation, anonymity, confidentiality and transparency were upheld as discussed in sections below (Crow, *et al.*, 2006; Berg, 1995).

3.5.1. Informed Consent

Permission to carry out an investigation was sought from all stakeholders, particularly the research participants who are seen to be doing the researcher a favour (Bell, 1999:42). Access and consent were negotiated and obtained at two levels – the care home and the individual. The access formality with the care homes took place during the scoping study and was straightforward. However the second level of negotiation for access and consent needed more effort i.e. with individual participants (residents, staff and management). This will be discussed below.

The first task in my field work was to ensure that the research participants did not feel coerced to take part in it. Hence, it was important to get informed consent for participation. This involved asking the research participants to read and sign an informed consent request letter which described the purpose of the research, its procedures, risks, the recording, researcher's role and the right to withdraw (see appendix 2). An assurance was given in the letter that all the responses would be anonymous and confidential and for purely academic purpose. Most research participants felt anxious about these documents. Many of them were illiterate and

some were simply averse to the concept of reading and signing written consent forms. Hence, I decided to use verbal consent and recorded it for all the participants. This was during the participant observation, and again before the photographs and interviews.

I began by attempting to explain to the participants in Konkani or English who I was and what I was going to do in the home during my presence there. I spoke to them about the aims of my research, the information that I would be hoping to get from them and how I would be using it i.e. for the completion of my PhD. Scope was left for clarification and the option to opt out was given (Fine and Sandstorm, 1988). In response to this, most residents verbally gave their assent. This was followed by asking the residents what they understood about my study, particularly those selected for interviews and they demonstrated an understanding through some kind of a verbal response. However, my interactions with them later made me understand the complexity of the situation: they did realise my physical presence but over time they forgot about my researcher identity. They just associated me with other identities such as 'nurse', 'sister', 'doctor', 'social worker', 'friend', and sometimes 'daughter' or 'granddaughter'. This was evident in many of my interactions:

> *'I was speaking to Sarita, she was in bit of pain as she had a fall the previous day. While speaking she said to me: "You were instructing the nurse yesterday about which medicine would be the best, right? It is because of doctors like you we are fit here. You stay here; please do not leave this home as we need doctors here." (Field notes, Private home, September 2011)*

> *'Arjun, a retired school teacher who is still very active at the educational front, introduced me to other residents as his granddaughter.' (Field notes, Private home, September 2011)*

The residents, nevertheless, invested their trust in me; they were willing to let me make use of whatever I found relevant from their conversations and actions. In those cases (only two) where they wanted something to be kept confidential and not used as a part of my research, they conveyed that to me and I respected their decision and kept those conversations or events outside the purview of my research. In spite of their lack of interest in the actual research, I used to discuss with them what I

included in my field notes every now and then, not only to test its validity but also to share it with them.

A final point to be made in this section is that identifying a person with limited capacity is difficult, and all the more so in India where the diagnostic tools and dementia laws are not yet well developed. The management, staff and volunteers familiar with the residents and their level of cognitive decline were consulted to ascertain the capacity of the older residents to provide consent to participate in the research project. Their recommendations were heeded.

3.5.2. Privacy, Confidentiality and Anonymity

My physical presence alone may have altered participants' behaviour, especially that of the staff.

> *'On the last day of my observation in the Government home, I was talking to one of the staff and thanking her. At this time she confided and told me that she did not like it when I asked her even casual questions about her actions, in front of the residents. (I had done that only once, actually). However, she told me that this question of mine made her very cautious of my presence and she felt relieved for she would no longer feel watched'. (Field notes, Government home, September, 2011)*

This was a very stark revelation. It was very emotional for me and potentially risky to my research, too. I am not sure whether other staff felt this way but when I checked, the rest confided that they felt comfortable in my presence. Besides their verbal affirmation, non-verbal cues were also manifested to demonstrate this comfort:

> '*Jaunita was verbally abusing a fellow resident. Savita (staff) had scolded Jaunita, given her a smack and forced her into bed. On this day Savita and I were having lunch together. I casually asked her about the incident and she told me that this is her disciplining technique. She said that this is their second childhood, so like children they should be reprimanded when they do something wrong'. (Field notes, Government home, September, 2011)*

Without commenting on the incident at this level (see page 68 for discussion on responsibility of the researcher), the frank nature of this conversation gave me a feeling that at least most of the staff were behaving in a natural manner. The

implication is that the staff saw me as someone interested in their work and keen to listen to their side of the explanation.

Maintaining the anonymity of respondents and concealing the identity of the setting is important (Kayser-Jones & Koenig, 1994). This is even more so in the case of the care home, considering the power dynamics that may exist between the older people, the staff, and the management, and the small sizes of the care homes which may make it easy for the resident to be identified by staff or management and hence lead to a potential conflict situation. The residents may also disclose events or incidents that are highly confidential. In the light of the above, anonymity and confidentiality become two important ethical pillars to prevent adverse effects on the research and the researched. To this end, I informed all my gatekeepers in the beginning that the anonymity of institutions and their precise geographical location would be preserved in all my future reports and publications, including this thesis. Similarly, staff and resident anonymity and confidentiality were strictly maintained throughout the research process. In my analysis, all forms of identification were expunged and pseudonyms used throughout. To sustain confidentiality, all the raw data related to this study are saved in a password protected system (only known to me) and will remain there till 2016, after which it will be destroyed. All this was communicated to the research participants from the beginning of my fieldwork.

3.5.3. Vulnerability and Preventing Harm

Another ethical issue that arises in my research is the potential vulnerability of the older people involved in my research. This may stem from the unequal power relations which they may have with the researcher, the staff, and fellow residents. This vulnerability originates firstly from a physical and mental dependency and, secondly, from a structural dynamic in an institution through which their position as a social, political and economic actor is marginalised. This vulnerability can include the risk of exploitation and an impaired ability to understand information. Hence, the responsibility rested with me to ensure that their best interests and human rights were maintained (National Health & Medical Research Council (Australia), 2007). I would like to state that during the entire research process I have striven to abide by the ethical code of the International Federation of Social Workers (IFSW, 2004) and the codes of practice for social service workers and employers of social service

workers (Scottish Social Services Council, 2009). In addition I have also followed the procedures adopted by the Research and Ethics Committee of the School of Social and Political Sciences, University of Edinburgh (which comply with the ESRC Research Ethics Framework). An ethical audit (level 2) was also performed before going to the field (See appendix 6). As Fine and Sandstrom (1988:75) suggest, I also strove to follow the three 'Rs': 'responsibility, respect and reflection'.

However, as I went about my study, I felt quite powerless as to the 'whistle blowing responsibility' mentioned in the ethics forms, as I was not sure that I would or could do much. It was very upsetting for me to face the fact that there was very little that I could do about the residents' circumstances. Attempts were definitely made particularly when my opinion was sought by the management, staff and residents. I also informally spoke to staff about variety of mechanisms available to them in caring for the residents and the problems of the methods they were using.

Within the confines of my field work and methods used, I strove to maintain the moral responsibility invested in me as a researcher, that is, to make sure my research strategy and the methods I used were not against the interests of any participant in my study. My participant observation was non-interventional and did not modify or interfere with the residents' usual care or daily routine. The observations were no different to the residents being observed by the staff. Residents were not observed during bathing or toileting, in order to preserve their privacy.

Literature has shown concerns over institutionalised research participants feeling an overwhelming reluctance to criticise care, or feeling coerced to participate in research as a 'captive audience' (Addington-Hall, 2002). During my research, however, I saw that many residents regarded their participation in the study as a valuable contribution to the future of others and that such participation could have substantial benefits (Chouliara *et al.*, 2004; Hutchinson *et al*., 1994). When asked for consent to participate the following statements were made:

> *"I am most happy to help; I will contribute at least something and feel satisfied during my last days" (Leena, Resident, Religious home)*

> *"You are asking my permission, I am honoured, we are only ordered here, no one even bothers if we are happy or not;*

> *they just do their things. Thank you for asking my permission" (Alice, Resident, Government home)*

Some interviewees took pleasure in answering the questions as they felt that this showed that they were not suffering from cognitive problems:

> *"Perhaps it's because I can talk better and converse with better than some of the people here who have memory problem, and perhaps it's because I'm more...brainy." (Rajan, Resident, Private home)*

> *"I'm glad I've got the brain to answer you, really." (Laxmi, Resident, Government home)*

On the other hand, predictably, there were some individuals who were more reserved than others. I believe that they were more private or perhaps just refused to talk in order to avoid remembering painful past experiences. For instance, I was talking to a female resident for about an hour and she was very cooperative. She spoke at length about her life and experiences at the home. However, she then suddenly changed her mind, saying she did not want to do it. She got too upset and said she didn't want to remember what had gone on. I told her that we didn't have to put it in the interview if she did not want to, but she could talk if she wished, but she just refused and I obliged. I am not sure what happened, whether she had a problem sharing her experiences with me, or she was afraid of her experience going public, or she just did not want to remember her past. Another gentleman in the Government home was very irritated when I approached him for an interview. He not only refused but also said that I upset him.

There were also some residents who were overly conscious of the interviews.

> *"Well, I wondered why you selected me, and what you were going to do to me. I hope I answered right." (Laxmi, Resident, Government home)*

> *"I found it difficult, when I first came in, to co-operate with the staff. They didn't have a lot of patience. Perhaps I shouldn't say this, should I?" (Violet, Resident, Religious home)*

This could indicate concerns about reprisals from the staff and the desire to maintain the status quo of their 'home' environment. In all cases, I tried to reassure the residents several times during the course of the interview that there were no right or

wrong answers to the questions, and that all views were useful and valid, and would be kept confidential.

One of the most notable observations in conducting this research was the desire of the residents to discuss a wide range of issues relating to dignity which could be seen as particularly sensitive and/or emotionally challenging for older people living in an institutional environment. These issues included the multiple losses many of them had already experienced (their homes, family and friends, and their independence), as well as considering their future decline in health and death. Nevertheless, most appreciated the opportunity to be heard and to make a useful contribution, and they were positive about taking part in the study. Their views have added to my understanding of the concerns of older people in homes to maintaining a sense of dignity. The ethical guidelines that I started off with, served as pointers rather than an instruction manual. Throughout the research I tried to remain sensitive to my respondents and to be careful that I did not cause them any harm or distress. By ensuring a relation of mutual respect, non-coercion, and non-manipulation, I tried to balance my research interest with the interests of the researched.

3.6. Challenges

Besides the ethical dilemmas reflected in the previous section, there were also more general and overarching issues which I faced during my study. Some of these challenges were specifically related to the issue of researching older people and care homes while there were also the more general issues of reliability, validity, generalizability of data, and other such concerns.

3.6.1. Time

Finding time to conduct the interviews both with the staff and the residents was difficult. There was a need to avoid busy times of the day, such as mealtimes or visits by doctors, hairdressers, and the like. This suggests that I had to seize opportunities to approach residents, preferably allowing them time to recover from previous activities before commencing the interview. For example, I avoided interviews with the residents after lunch or late in the evenings as they were often tired and felt lethargic at this time. In contrast, the staff members were relatively free at this time and so I interviewed them then. However, most interviews were

interrupted in order to adhere to the house routines, a major challenge for continuity as in the majority of cases I had to start over again. Another challenge here was that I had to spend a great deal of time waiting for the residents to finish their activities and interviews were often postponed at a moment's notice if the resident did not feel well, had an unexpected visitor, or simply did not 'feel' like participating at that moment. While acknowledging that this was very frustrating and thus delayed my field work, I always tried to be sensitive to the needs of the residents and respected their decision not to be interviewed at the agreed time, without asking them to justify their decision.

3.6.2. Privacy

Since all interviews covered issues regarding the care issues in the home, privacy of the interview was very important. In most cases lack of privacy was a major issue particularly with the residents. This was because the residents had no private areas. Either this was due to the dormitory system, or the staff would enter the area during the course of an interview. I tried talking to the staff and telling them about the need for privacy during the interview. Unfortunately, they would comment loudly and say to the resident, *'Now you tell her all tales about us'*. I managed to tackle this problem in the Private home and Religious homes by going for walks with the residents or sitting in the home's garden (This was their routine; I did not impose the walks). It was with the Government home that I found it difficult to negotiate privacy. It was never sorted out. The most notable observation of lack of privacy was:

> *'When I was interviewing Milena (resident) today, Kareena (staff) came and seated herself. I tried to explain to Kareena that I was interviewing Milena and we may need some privacy. To this Kareena said to Milena "Oh, she may need some help in remembering events which she may have forgotten, don't you, Milena?" to which Milena replied positively. Here I could not object. To the next two question I asked, Kareena 'prompted' Milena to respond, or reminded her of events which she had forgotten. Milena eventually delegated all responsibility for answering questions to Kareena, which would affect the objectivity and validity of Milena's response. I therefore drew the interview to a close.' (Field notes, Government home, August 2011)*

However, the residents were very frank while narrating their experiences and spoke in a low tone in the presence of the staff.

3.6.3. Changing perceptions

Going into fieldwork without much prior research experience in care homes, I had certain ideas and questions in mind on which I had planned to base the fieldwork. One such main idea was to recount the stories of the residents' difficult conditions of existence as my readings and previous volunteering in a care home had seemed to suggest. But spending a considerable period of time in the field, my experiences there confirmed that a uni-dimensional story of dependency is invalid. There was also a strong narrative of resistance and coping mechanisms interspersed within it. To capture this, I needed to change my focus and some of the data collected in the initial period that showed this gap. As my experiences in the fieldwork modified my preconceived ideas, I tried to remain reflexive in order to address and accommodate these changes within the process of data collection. Periodically I used these experiences to evaluate the direction in which the data collection proceeded.

3.6.4. Missing links

Though my research focuses on the residents in care homes, I would have liked to have captured the family perspective more than I was able to. I had intended to talk to families who visited the residents. However, I came across only 15 family visits in total during my entire field work. Two family members were willing to speak and they co-operated in the interviews (though not at length); the others simply refused. The majority of the families, who refused, preferred to keep their visits very private. The families did not really want to introduce themselves or speak at all. One of the reasons may be the stigma of shame in Goa which is attached to the families who have put their parents or relatives in care homes as reflected in the previous chapter (see page 22-23). Secondly, some residents also resented me talking to their families. One family visit was particularly awkward as the resident reacted very badly on seeing the family. He asked them to leave as soon as possible and never to come back; he also continued verbally abusing them the whole evening. Feelings of rejection and anger spoke loud in his behaviour and the fact that he had not been

mentally prepared for staying in a care home and yet had been forced to agree. This experience made me realise that my speaking to families at that point could also draw resentment from the residents. For these two reasons, I eventually gave up my intention of including family members in my interviews and tried to concentrate on the actors within the care homes.

Interviews with families may have enabled me to provide more robust information and a different perspective. It may have drawn me closer to the social, economic, and political influences that determine the lives and experiences of older people in care homes in Goa. Much of the data that I gathered about these influences was through the residents or a casual conversation with them when the families visited the residents.

An important point needs to be made in relation to my position as a young researcher creating missing links. I could never identify with an older person in a care home. Hence, I could only be a keen researcher, a listener interested in their lives. I maintained this keenness and genuine interest in their lives throughout my fieldwork. This issue will be discussed in greater detail in the positionality section. However, the point I want to make here is that my being of a younger age group was seen as a particular difficulty when speaking on topics regarding sexuality. By sexuality I mean physical intimacy, the need and sensation of feeling loved, romancing another, affection, touch, and a sense of personal attractiveness (Rheaume and Mitty, 2008; Hajjar and Kamel, 2004). Including sexuality would have helped me understand better the role of care homes in helping residents achieve a fulfilling sex life, or become frustrated in attempting to do so. In this regard I would be able to probe how issues of privacy, practices of the home including segregation of sexes, attitudes of staff, perception of family members, lack of an able sexual partner, and physical and cognitive limitations play a role in enabling or preventing sexual expression among residents. This evidence would help in understanding the values and norms that governed the experience of sexuality among the residents and the difference in these experiences and permissiveness between genders. When exploring sexual expression of residents with the staff, there were two impressions, one, non-existence of sexuality needs or expressions among the residents given their age and second, staff tend to view residents' attempt at sexual expression as

'problem' behaviour and hence should be curtailed (see for example the interaction between Milena and Kareena in the Government Home on page 189). When probing sexuality expressions of residents in my study this was taboo topic for discussion, particularly coming from someone who is almost four to five decades younger. At the same time, I was addressed as *'beti', 'Bai'* (daughter), or *'Naat'* (granddaughter) by many residents that put me in a lower position according to their norms, especially in discussing issues of sexuality. They found it embarrassing to talk to me about sexuality issues. The common comments I received when attempting to talk on these issues were:

> *"What are you talking, sex at this age? Have some shame" (Carmen, Resident, Government home)*

> *"You must not ask these questions, they are very inappropriate" (Leena, Resident, Religious home)*

The above comments not only created an uncomfortable atmosphere for the residents and me but more importantly depict the discomfort and awkwardness felt by the residents. Hence, even though I had intended to include sexuality, the discomfort felt by both me and the residents led me to avoiding this element in my research.

3.6.5. Disillusionment about Potential Benefits

From the beginning of my fieldwork, I had informed the management, the staff, and the residents that my research would be used in fulfilment of my PhD. By saying this I sought to lay down the ground realities and not raise in them hopes of any direct benefits for them. However, even with this clarification, the respondents carried expectations of potential benefits from my research. This ranged from making a difference to their lives through policy implications, to me going to the UK, getting my PhD and forgetting all about them. To avoid any disillusionment in the minds of the residents and the staff I repeatedly reminded them of the fact that I was a student and in fact powerless to change their condition. Even though this may have helped me to convince them, I was not able to convince myself. During field work, data analysis, and the writing up phase, I was time and again brought face-to-face with the more fundamental issue of the responsibility of the social researcher. Was this to be only a part of building my professional career? This thought presented the biggest challenge of my PhD: the threat of disillusionment. I had

formed genuine relationships with my respondents; they had shared with me their miseries and pains, and I felt deeply for them. I felt a sense of despair at the knowledge that I could not do anything to improve their condition, especially when most of them, aware of this fact, had willingly let me make their lives a study for my qualifications. Caulfield (1979) speaks of how the tendency to gain for a personal career benefit remains so ingrained in the profession that it often becomes difficult for the researcher to maintain his/her commitment to respond to the needs and problems of the community as defined by the community itself. Davis (1979) holds that it is the ethical responsibility of social researchers to write and speak the 'truth'. But, the idea of an absolute truth is relative. To offset this I strove to maintain an honest account of what I saw and understood. In listening to the stories and reproducing them honestly but within a framework of the critical debates within the social sciences, I hope that my fieldwork will strike a balance between personal goals and implications of social research.

3.6.6. Bias and Objectivity

Research by its very nature is biased and value laden because it is a human activity (Harding, 1991). Caulfield (1979) holds that taking sides is inevitable and even necessary in social research as neutrality, in reality is partiality to an existing status quo. Along the same line, I make no claims of objectivity or value neutrality: indeed, in many ways, my close relationships with the residents provided me with greater access to their thoughts and feelings. I have tried to make my values and biases explicit in the next section on positionality although my intense discomfort with the way in which I perceive long-term care, my dislike of medical approaches to care, and my concerns about a privatised, for-profit industry caring for vulnerable populations, will inevitably create a certain bias. But no research is without its flaws or biases; I simply attempt to be explicit about and be aware of these factors in my own research. With reflexivity and self-evaluation these biases can be invaluable guides to data collection and account generation emerging from it. In addition to recognizing the biases that I possessed, it was also important to strike a balance so as not to become the spokesperson for only a particular section of the social setting being studied. As Hammersley (1998) points out, one's role as a sympathetic researcher must be clearly distinguishable from a member of the group. In order to

achieve that, I tried to capture as many different shades of opinion as I could. I spoke to residents from three care homes, the staff, and the management. This elicited different points of view and helped me in forming what I hope to be a reasonably well informed opinion about the issues in which I am interested.

3.6.7. Positionality of the researcher

Identifying myself as a Goan with a common ethnicity, common language and personal socialisation placed me firmly in the realms of an insider in the research. Acknowledging the insider status critically is, however, a necessary exercise for the ethnographer to strengthen objectivity (Waghmore, 2011). Interrogating myself from this perspective, I found that in effect my position was much more that of an outsider than an insider (Dewing, 2009, Wiersma, 2007).

I was a 27 year old woman, relatively young in comparison to the residents who were all over the age of 60. While age is a socially constructed category, there were differences between the residents and myself in the course of the fieldwork. I represented their past, and they represented my future. I could also potentially represent their pain, since I represented what was and what was not in them. I still have what many of them had lost – parents, siblings, or friends. I am experiencing the life stage they once had and have now lost – a family or a career. I am their memories. And yet, despite these differences in our current situations, there are also many similarities. Memories do not always bring pain, and as such, they can relive their lives as they are a part of me living my life. They teach me life lessons that can only be known from experience. Many times, I see myself as more similar to, than different from, them. Yet, in terms of current life circumstances, I am vastly different. They represent my fears. Will this be me one day? How will I live? Survive? Cope? Even more, what must it be like to lose control of your bodily functions? I am able to care for myself now. What must it be like to not be able to go the bathroom by yourself? Not to be able to turn your body over in bed? Not to be able to take a step without someone there beside you? I cannot pretend to understand this experience, and in this way, my research and my 'knowledge' is often situated outside of these experiences. This, of course, means that my research only presents a specific perspective, since the bodily experience is a significant part of people's lives (Twigg, 2004). Yet, these residents are much more than the sum of their functioning,

or than of their body. And, it is in this way that we become entwined. The values I hold dear – of family, spirituality, nature, work, and responsibility – are the ones that many of them did hold dear as well. The lessons and experiences of life, and the living history that they possess, teach me about another era. To a great degree, the knowledge I gained from the field both in past research and work experiences, and the things I learned, was dependent on my relationships with the residents. To some degree, I wonder how much I took as opposed to how much I gave. Perhaps, I was one of the few who did not just listen, but who saw the residents as not so different from myself. But regardless of how I view us as similar or different, it is inevitable that I present a view of the residents through my eyes – that of a female, unmarried, middle class individual doing a PhD abroad, unemployed, with the perspective of youth. To pretend anything differently is to assume the authority of a non-present other, and as such to present my findings as truth. In reality, my research and my knowledge are situated. If we begin from the world as we actually experience it, it is at least possible to see that we are indeed located and that what we know of the other is conditional upon that location. There are and must be different experiences of the world and different bases of experience. We must not do away with them by taking advantage of our academic attempt to construct a sociological version that we then impose upon them as their reality. We may not rewrite the other's world or impose upon it a conceptual framework that extracts from it what fits with ours. Their reality, their varieties of experience, must be an unconditional datum. It is the place from which inquiry begins (Smith, 1990). These ways in which I am different, and in which I am the same as the residents, provide the necessity for my self-reflection throughout the process of this research, and for my awareness of the ways in which my relationships with the residents were structured and based on these similarities and differences. As such, it was of utmost importance that my individual self and my personhood were included in the research and in my reflections. These might have worked both ways in shaping their responses towards me as well as shaping my interpretation of their behaviours and perceptions. My fieldwork remained for me this process of mutual learning.

3.6.8. Generalisation

Goa, my field site as discussed earlier, is unique in many ways when compared with other states in India with regard to its historical trends, colonial past, demographic trends, economic development, and political commitment to older people. However, there are equally a number of features common to other states in India with regards to the context of the study. They include rising trends in the institutionalisation of older people, the absence of a policy on older people and care homes, and changes in the family system as a result of changing economic conditions. Still, the current study by intentionally researching three care homes within Goa to add a comparative element. What implications does a specific field-oriented research hold for the generalisability of the observations made, or conclusions drawn, to either the residents in care homes in general or specifically in India?

The major methodological question that arises here includes whether it is possible to extrapolate the study findings under these circumstances to other states or other cases within Goa. Does this study really need to generalise its findings? Whilst authors from the positivist tradition are sceptical of making generalisation on the basis of one or few cases (De Vaus, 2001; Bechhofer and Paterson, 2000), authors from the naturalistic inquiry tradition have different views on this. Stake (1998) disagrees with any law-like generalisation of conventional social science in a case study approach. Instead, he advocates the idea of 'naturalistic generalisation', which is based on the researcher's tacit knowledge. In essence, he argues that generalisation is not always necessary in research, and even the thick description of particularity of a case has its own merits. Lincoln and Guba (1985), however, are neither convinced by Stake's alternative 'naturalistic generalisation' argument nor by the positivist monism. They suggest that 'transferability' of conclusion from one context (or case) to another is possible in a case study based on its 'fit' i.e. the similarity between two contexts.

Is generalisation, however, all that useful? Flyvbjerg (2006) makes a powerful critique of viewing generalisability as the only desirable outcome. He holds that context dependent knowledge exists more widely and is often more useful. A single detailed case study can form an important part by developing an understanding

and having implications. Finally, talking about the data with a focus on generalisation actually results in the loss of the voices of the residents whose story it seeks to tell. Personal experiences, aspirations, and understandings need to be accommodated. The analysis, thus, needs to strike a balance between the generalisations made and the personal experiences gathered. Subsequently, by drawing out maximum variation, the data generated were applicable to the whole range of care homes lying within the three categories, thus making the research findings more generalisable. At the same time, the specific differences between and within the care homes had to be accommodated.

The above arguments show that there is no compulsion in case study ethnographic research to make generalisations. Yet, it is possible for the current study to make attempts for transferability based on the logic that it provides, based on Lincoln and Guba's argument of similarities between two contexts. The variations are thought to provide the opportunity for literal and theoretical replication of the cases, though not a statistical one. This implies 'fittingness' (Guba and Lincoln, 1982) of the situations in the cases in the degree to which they match with situations in other cases, thus highlighting the context in which a particular behaviour or phenomenon occurs. This can allow transferability of the cases to others.

3.6.9. Validity

Finally, accounts of ethnographic research, semi-structured interviews and group discussions are, to a great extent, interpretive accounts of the researcher. This element makes the methodology open to criticisms about validity. Gubrium and Holstein (1994) argue that these criticisms should be treated as an interpretive resource rather than a deterministic condition, as circumstances for social construction, and as a social construction itself. Though these suspicions about validity cannot be ignored, the interpretive nature of ethnography can also be viewed as its strength, especially if it is rich in local meanings and it shares constructs with the researched. Through a period of observation and interaction, I slowly started getting a better understanding of these shared constructs, although surely there must have remained gaps till the end. Rather than branding different actions as belonging to one category or the other, I remained as far as possible sensitive to the residents' understanding of these actions and the attached meanings. It is for the same reason,

that my interviews followed participant observation – to clarify those categories which I had set up during my participant observation.

As a researcher, what I observe and experience is influenced by who I am, so it was inevitable that I would be subjective in my interpretation. This can skew the data gathered and analysed. However, transparency in analysis can be achieved by being aware of the role I held as a researcher which in turn describes my positionality. Therefore, an understanding of my role in the field and the respondent's reaction to this is an important element in shaping the analysis of this thesis.

As this research was conducted 'overtly' in the field, my principal identity as a researcher was visible to all the participants in the research settings. However, my other identities as mentioned in the positionality section above: female, young, unmarried, middle class person doing a PhD abroad, and unemployed, were constructed, interpreted, and negotiated differently at different times by the respondents in the field situations.

> *'one day, when I was taking down notes, Nilu, resident in the Private home, came towards me and asked what I was doing. I said I was writing down what I observed during the day at the home. After a small pause she asked me if I didn't work. Rather surprised with her question at that time I asked, 'what work?' She simply repeated with a stress on 'work' (Field notes, Private home, September 2011)*

Nilu's question was perhaps a reaction to my 'not so fixed role' in the institution. This might have made her think that I was not part of the staff team. It reminded me of what Woods (1983) described about the presentation of subjective 'I', that is, the presentation of self to others, and objective 'me', that is, how I was perceived by others, in the field situation. Indeed, throughout my observation I did not have any particular fixed role in the institutions. Rather, I had donned diverse roles in the field. For instance, there were times when the staff treated me like a colleague and asked me to help around, when some residents perceived me as a friend with whom they shared their personal stories and other residents as a staff member. In the Government home, for instance, Savita (staff) described me to outsiders as a *'sort of social worker doing social service'*. This perception was not helped by the fact that I apparently dressed and spoke like one (the staff wore uniforms). Being a social

worker was a high status occupation in the eyes of both the staff and residents. This meant that the staff and residents may have tried to put their best behaviour forward during my presence.

These multiple roles have implicit difficulties. One is from the point of view of the participants being studied: at time it leads to confusion in their minds regarding my roles. This was affecting my data collection as they became self-conscious the minute I would ask some questions, at least during the initial phase. Secondly the emotional demands I had to respond to were sometimes draining for me personally, especially, in mediating firstly between the research and the care home and secondly between the management, staff, and the older people.

Access into the lives of the residents as a researcher was restricted in two ways: as an able bodied young researcher and as a staff member. Neither of these warrants playing an equal role with the older people. Moreover, my access to staff relationships was restricted as I was an outsider observing their work. As far as the staff members were concerned, the research was about older people in care homes while the older people understood it to be about staff. Hence no group was particularly anxious. Indeed, in common with most participant observer studies, it was genuinely difficult to be clear about the precise nature of the research at any one time.

Use of a combination of methods helped me to collate my interpretations with that of the residents, which proved valuable. I also sent field reports to my supervisors to cross check with them that the observations I was making were logically and theoretically tenable. This is not to say that interpretations were eluded from my data and its analysis. I continued to be interpretative. However, through the above checks and by trying to maintain a balanced perspective of events and accounts I sought to place the data within a broader framework of critical debates on institutional care.

3.7. Conclusion

This chapter has described the decisions that were made in the design and conduct of my study of the experiences of residents in care homes most of whom had never taken part in any research before. My aim was to carry out a qualitative ethnographic study that would highlight the residents' experiences. I have described

the step by step efforts that were made to actively engage with participants in this process. Some of the theoretical and methodological frameworks that underpinned the entire study as well as the ethical, theoretical and practical issues and challenges that formed part of my fieldwork experience have also been explored and discussed. At all times I maintained my commitment to remain honest to my participants and the research itself. This entire chapter has also illustrated the reflexive conditioning and assessment of the data as they were collected and analysed, which further contributed to newer insights.

The selected homes and research participants reflected the social phenomenon I was researching: varied and diverse, constantly changing and subjective. I now turn to providing analytical descriptions of the three homes and the detailed socio-economic characteristics of the research participants.

Chapter 4: Description of the setting: A snapshot

4.1. Introduction

In this chapter I provide a snapshot description of the important features of the three care homes where I conducted my fieldwork. An understanding of these is important for making any analysis of residents' lived experiences within them. Beginning with the locational and contextual information of the three care homes, I will go on to describe a typical day in each of the homes. Following this, I will provide an overview of the research participants interviewed in this study. The aim is to set the background for the future analysis of what all these elements mean for the residents' experiences.

4.2. Setting the context

As the data were gathered in a specific social, cultural and economic context, outlining the context is as important as the data themself for inferring any meaningful interpretations. Hence, in this section, I aim to describe the contextual data on the three care homes:

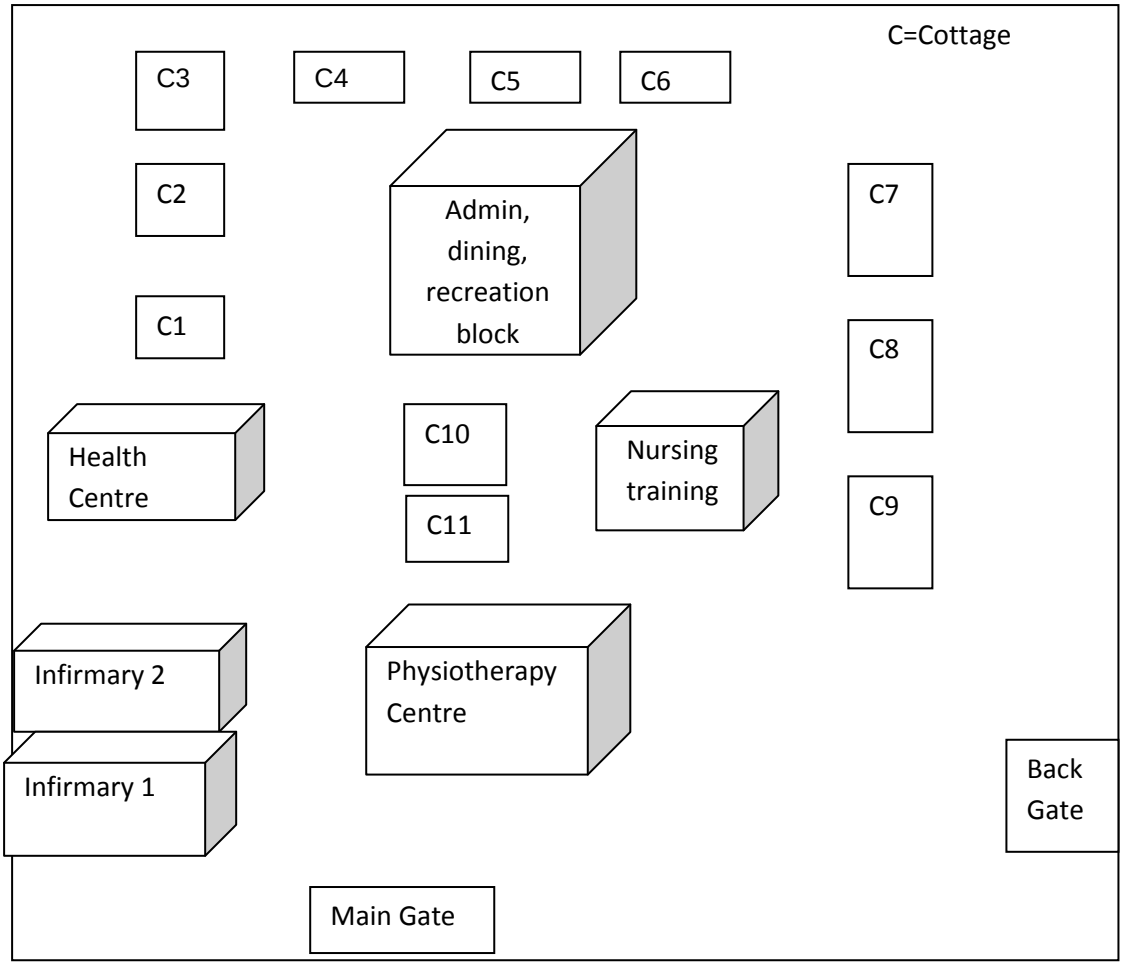
4.2.1. Origin

The Private home was built as a non-profit making organisation registered under the Public Trust Act as well as the Society's Registration Act. The Government home is run by the Institute of Public Assistance. This institute, commonly known as "Provedoria" which means "Provide", was set up in 1947 by the then Portuguese Government ruling Goa. The main objective of this institute as mentioned in its charter is 'to cater to the welfare of the underprivileged and the downtrodden'. It is with this motive that it runs care homes for older people. There are eight other care homes run by the Provedoria at different places in Goa. The Religious home on the other hand, began when a member of the village gifted her ancestral house and the vast property around it to a group of Roman Catholic religious sisters who intended to open a care home. The physical structure of the house has been maintained in its original form and hence gives a feeling of entering any other house in the village.

4.2.2. Physical portrait and facilities

The Private home is constructed on a piece of land measuring 25000 square meters. It is situated at the foot of a hillock and has a green and picturesque landscape. It is located in a village which is 5 kilometres from the nearest city. Public transport is not accessible from the home; one either needs to walk to the nearest bus station located 4 kilometres away or else call a private taxi. There is an isolated feel to the home, both in terms of accessibility as well as the neighbourhood. However a number of religious places are within a walkable distance which the residents can visit.

Figure 4.1: Layout of the Private home



On entering the Private home, the feeling of witnessing a retirement village is overwhelming. As shown in figure 4.1, above, the physically weak and incapable were housed in two separate buildings (infirmary 1 and 2) close to the entrance. In specific terms, these two buildings accommodate thirty residents: those who had high

physical dependency needs. This area is paramedical, one with a round-the-clock medical service including the attendance of a nurse, an *aayah* (servant) and a wardboy to assist the 'lying-in elders'. According to the home's manual, a consultant doctor pays visits regularly and is also available 'on call' in an emergency. After his round at the infirmaries, the (consultant) doctor is normally available for consultation for a few hours at the 'Health Centre' if the residents wish to consult him.

The complex also contains eleven cottages. These cottages have been donated by various donors. These cottages accommodate residents who are physically and mentally fit. These residents were the focus of my research. Each cottage has two ensuite rooms. Each room accommodates two residents; preference is given for couples to share a room (so four residents per cottage). If not, the rooms are allocated on the basis of the sex of the residents, that is, same sex residents share a room and a cottage implying segregation by sex. The allocation of rooms can be changed at the discretion of the management.

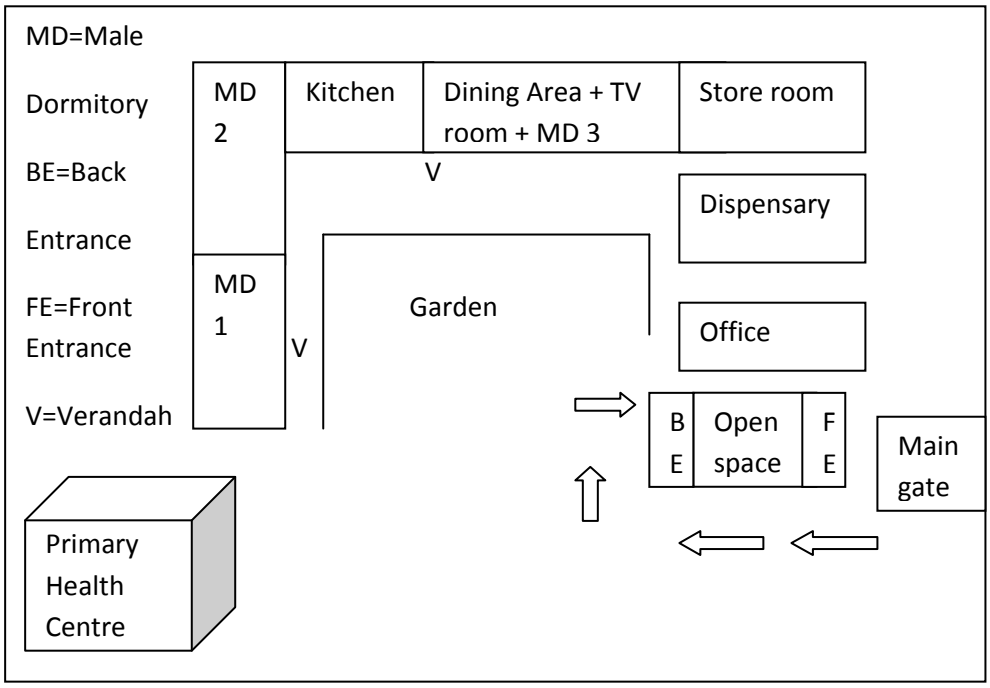
In the centre of the complex is the administrative block. This block, besides housing the management offices, also encompasses the dining, recreation and library rooms where the residents gather during meal and leisure times. An important point to be mentioned here (which was gathered during conversations with the manager and the residents) is that the residents need to be physically fit enough to walk from their cottage to the dining area five times a day to 'qualify' for living in the cottages (morning tea, breakfast, lunch, evening tea and dinner). If they are unable to do this they need to get admitted to the infirmary.[12] This building also has a multi-purpose hall where a variety of cultural programmes are held, including art classes for young children from the village. The home conducts these community activities. Other community activities include typewriting classes, and competitions for the local community. This provides opportunities for interaction between the residents and the wider community. The complex also houses physiotherapy cum day care centre in close proximity to both the cottages and the infirmary. This Centre runs three times a week and is manned by a single physiotherapist who assists the residents. A unique feature about this home is that it also runs a general Nursing Training Centre for

[12] Getting admitted to the infirmary is seen negatively by the residents; they consider it a step closer to death.

girls: following training here, the nurses need to do an internship with the infirmary attached to the home. This, besides giving them hands-on experience, also works to the advantage of the home.

The Government home is a double storied building. It is located in a village approximately 6 kms from the nearest city. Public transport plies along the route once every thirty minutes during the week, with irregular frequencies over weekends. There are fields overlooking the home but they are not visible to the residents. This is because the home is a U shaped building with the verandas facing the middle of it and the dormitories to the side and back of the building, as evident in figure 4.2, below. None of the verandas, windows or doors faces the road. The only entrance which faces the road was closed throughout the course of my field work, and a back entrance through the middle of the building had to be used. The campus is guarded by an old iron gate in the front, high walls at the sides and a thick forest area at the back. The neighbourhood on either side of the home is practically empty for around two kilometres, where residential areas begin.

Figure 4.2: Layout of the Government home ground floor



The residents have no telephone facilities available to them; hence they are seen bribing staff with gifts they receive from charity, to make telephone calls to their families and friends. The home also does not have a visitors' room, though there were not many visitors visiting. Those who did visit were received at the entrance marked as the open space in figure 4.2. Outside contact is very limited; for security reasons residents are not permitted to go out. The security reasons as explained by the manager mainly include the fear of the resident not returning as this will bring the home under public scrutiny. The feeling of living in a prison *"Amkam bedhi galea"* (when literally translated it reads *"we are in chains"*) was expressed by many residents. This feeling was contributed by the physical structure of the home – for example, the presence and constant locking of a big iron gate. The manager and staff, however, complained about the lack of visits from relatives, who after the initial admission do not keep in touch. The only outside contact many of the residents have is with members of social and religious organisations such as Rotary Club, Lions Club, Legion of Mary, St. Vincent de Paul Society and certain people who visit the home at the time of festivals bringing in food and clothing.

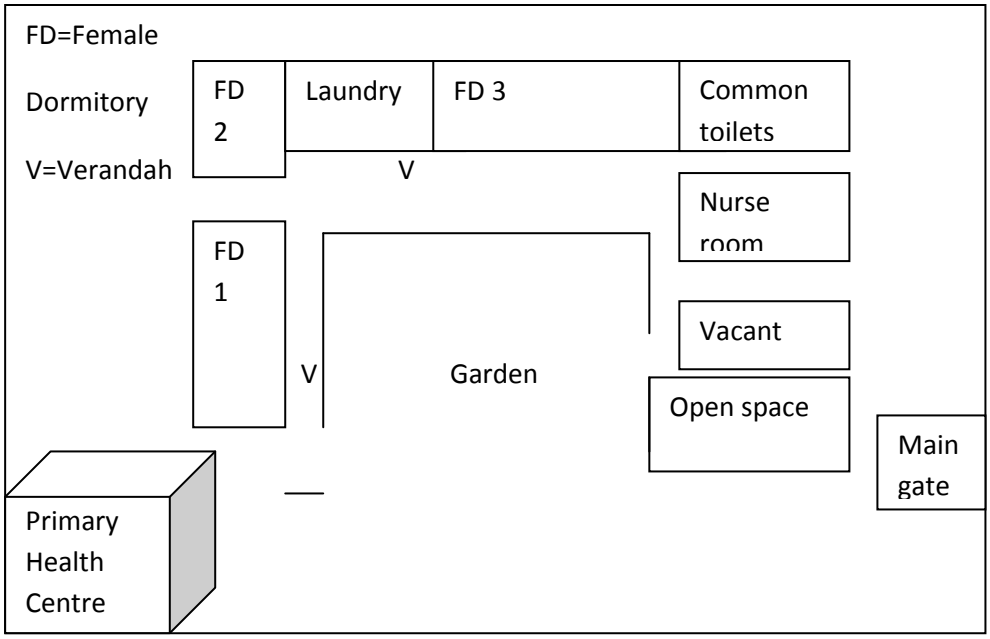
As seen in Figure 4.2 there are three male dormitories and they occupy the ground floor of the building. The mentally and physically incapable older males are admitted to the male dormitory 1. The able (mentally and physically) residents are admitted to male dormitory 2 and 3. It is these two dormitories and its occupants who were a focus of my study. Male dormitory 2 is a very crowded and dimly lit place accommodating fifteen residents with beds very close to each other. Male dormitory 3 is a busy place as there is usually some activity or other happening there: meals are served to residents, staff and residents watch television and it is also a dormitory for eight residents.

Meals are served in this area at lunch time; however supper and tea are served in respective dormitories from large aluminium buckets or pots.

> *I was here for the first time when supper was being served around 5 pm that is before the dormitory was locked up for the night. The food was served in the dormitory itself, from a big aluminium bucket. It was supposed to be a vegetable dish but what was seen was plenty of gravy with hardly any vegetables. Along with this the residents were served bread (Fieldnotes, Government home, June 2011)*

The Female dormitories are located on the first floor. They follow a similar structure to the Male ones. This is evident from figure 4.3. An important point to be noted here is that mixing between men and women was discouraged in the Government home. The physical structure also contributes to this segregation.

Figure 4.3: Layout of the Government home first floor



Each dormitory has a capacity for 10 residents. However, the dormitories include 15 residents or more and hence are crammed – with beds close to each other and very little space between the rows of beds. Each resident has a bed and a bed side table for their use. These tables have a small cupboard but do not have locks. There is no chair or wardrobe for the personal use of the resident. Boxes with clothes and other personal items (if any) are placed on shelves with the bed number, on a wall at the end of the dormitories.[13] There are benches available for sitting on the verandah. All the dormitories are poorly lit, lack proper ventilation and require a coat of paint. The bathrooms are small and do not have a western style commode in the

[13] Most of the residents do not have their own clothes, both linen and clothing is supplied from Government funds, the clothing was a green uniform till five years ago in all the provedoria homes. The reason for this was that, if a resident ran away from the home, he/she could be easily identified. However today due to lack of Government funds and higher security in homes the uniform usage is reduced. Donations of clothing from the public are accepted which are then distributed among residents.

toilet. There is no wheel chair access to any of the bathrooms. These dormitories are locked after 5 pm for security reasons and the residents cannot leave their dormitory until the next morning when a member of the staff comes to open the door. Again the security reason cited here by the manager is the fear that the residents may run away.

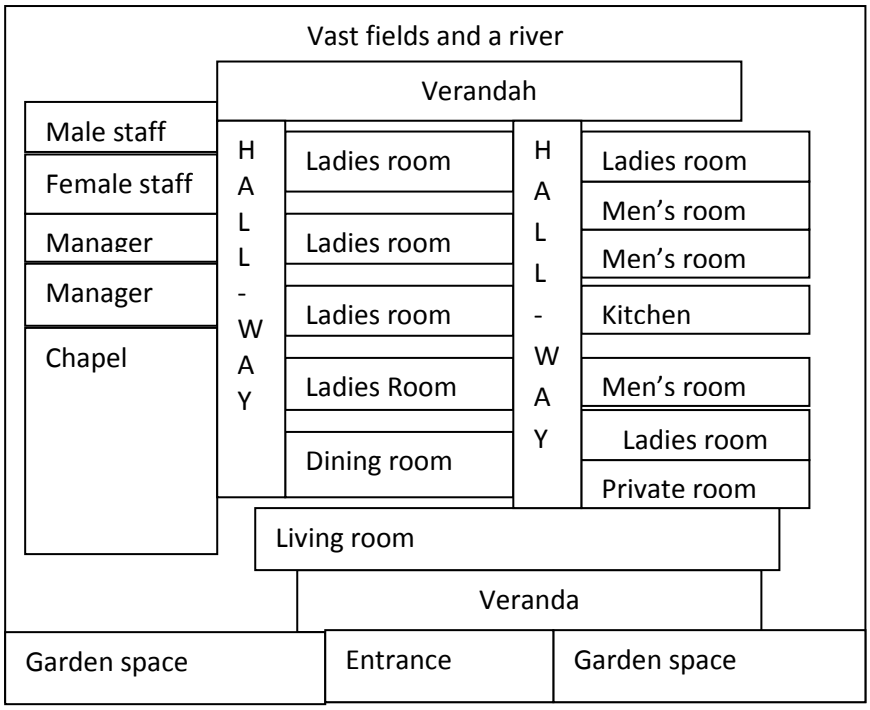
The living arrangements including the doubled storeyed structure without a lift, shared dormitory and toilet facilities often cause inconvenience to and conflict among the residents. All the toilets are Indian style and the home has an absence of bed pans when residents are ill. This causes major inconvenience, accidents and embarrassment to the residents during their toilet visits as reported in many interviews.

> *"I have got arthritis, have great pain in getting off the bed and rushing to the toilets: Sometimes I end up urinating along the way and then everyone shouts and makes fun of me; at the same time I cannot climb the stairs quickly with my plate after being served my food. I am mocked here as well by everyone. Is it my fault that I have this sickness?" (Carmen, Resident, Government home)*

The only source of recreation for the residents is the television which is located in the men's dormitory. This has led to a major contention between the staff and female residents. Firstly, the interaction between male and female residents is kept to a minimum as already noted earlier; hence, the presence of ladies in the male dormitory is seen as inappropriate. Secondly, the male staff have always been watching television and they consider that the television is there for their recreation, not the residents. Segregation by sex and regimentation are evidence of some physical characteristics that clearly impact on the experiences of residents.

The Religious home is situated in a village in Goa in the midst of other residential houses. Surrounding the house are also paddy fields, a church, and a grocery store. On entering the main gate one is surrounded by a garden area; a number of residents are seen walking around the garden with a rosary in their hands.

Figure 4.4: Layout of the Religious home



As evident from figure 4.4 at the entrance is a veranda where residents sit. The main area of the building begins with a living room which also has a television, a library cupboard and newspaper stand. To the right of the living room is a chapel, where the residents gather for prayer twice a day, morning and evening. The dining area comes next, with tables and chairs placed in the form of a café. The dining area has spaces allocated to each resident based on staff preference. It also has a kitchen area where the meals are cooked. The house accommodates 30 residents in ten en suite rooms. Each room accommodates between 2 to 4 residents. Each resident has a cupboard, a table with locker and a chair; an inspection is conducted monthly to check the cleanliness of these personal spaces (things that staff and management think useless are thrown away). Allocation of seats at the dining table and intrusion into the personal spaces of the residents are contentious elements in defining the staff-residents relationships.

4.2.3. Resident composition

There were many similarities between the three care homes in terms of the composition. Residents were between 60-80 years of age. Predictably, besides

Hindus and Christians there were no other religious groups present across all the three care homes. The ethnicity of the residents across all the three homes was Goan. Women were in a majority comprising almost 60% of the total number. Across all the three care homes, the majority of the residents were single i.e. never married, widowed or divorced. However, there were also some differences in the composition that existed between the three care homes

There were 70 residents in the Private home: 40 lived in cottages and 30 in the infirmary attached to the care home. The 40 residents who lived in cottages were the focus of my study. A majority of these residents were Hindu graduates who had held white collar jobs in the past. The residents were addressed by the staff as *'Kaka'* meaning uncle, 'Kaki' meaning aunty, *'Aie'* meaning mother, *Taie* meaning elder sister, '*Dada'* meaning grandfather and '*Dadi'* meaning grandmother. Visitors were encouraged to do the same.

The Government home comprised 75 residents: 40 able bodied between the age groups of 60 to 80 and 35 being bed-ridden or mentally incapable. Again it was the 40 residents who were the focus of my study. The population among the 40 residents came from lower and middle income groups. Among these residents there were an almost equal proportion of Christians and Hindus with a slight majority of the former. Residents belonged to various caste groups. There were also variations in educational qualification among residents. The majority however could not read or write. The residents were addressed as 'inmates' to outsiders and by their first name when staff were talking to them.

The Religious home included 35 residents. All of them had Goan Christian middle class backgrounds. The home claimed to be open to all religious faiths and the concentration of Christian residents could be because the management of the home was in the hands of Christian Religious. The residents were between the ages of 60 to 90. However, none of them were infirm and all could engage in logical conversations throughout my stay at the home. Residents were all literate, having a basic knowledge of reading and writing. Like the Government home, the residents in the Religious home too were addressed as "inmates" to outsiders and by their first name when talked to.

4.2.4. Staff Composition

The staff in all the three care homes operated in a very hierarchical manner. The staff consisted of a manager, assistant manager, a few nurses and 'servants' (care-attendants, domestic cleaners, cooks, laundry workers, gardeners and so on). The manager was seen as the supreme authority within the care home, responsible for the day to day running of the home. In the Religious home and Private home, the manager had the power to enrol and dismiss staff, give close attention to financial matters and the physical maintenance and repairs of the home. In the Government home however, this was taken care of by the higher Government officials: the Director and Assistant Director of *Provedoria* who were remotely associated with the daily affairs of the home but who determined to a large extent its workings. In all the three homes the manager supervised staff, diets, residents and the cleanliness of the home, which for them were the daily affairs of the home. In all the three homes new residents were briefed about the rules and regulations of the home by the manager. Although some rules were set out in a friendly style, nearly all served as reminders that the new residents were expected to conform closely to the routines of the home and to acknowledge the manager's authority. Below the manager were the assistant managers. In the Government home, there were two assistant managers whereas the Religious home had only one – the Private home was an exception as it had none. Predictably, the role of the assistant manager was restricted to assisting the manager in managing the daily tasks in the care homes. Below them were the general staff, the composition of whom differed between the three care homes. For example, in the Religious home, the assistant manager functioned as a nurse whereas in the Government home, the nurses were below the assistant manager whose work was restricted to administering medication and holding medical check-ups for the residents. The nurses in the Private home were restricted to the infirmary section. Below the nurses were the caretaker staff who were in constant contact with the residents. In comparison to the three care homes, it was the staff in the Government home who seemed to be most satisfied with their salary and benefits. Having provided an overall idea of the staff composition and hierarchy across the three care homes, I will now briefly describe some of the differences in each of the three homes.

The Private home was run by an external management and had appointed a manager to run the daily affairs of the home. The current manager was a 58 year old lady who had run the home for 10 years before leaving to run a children's home. She had now returned to managing the Private home and this was her third consecutive year. Both the residents and staff addressed the manager as *Taie* (elder sister). She was unmarried and claimed to have dedicated her entire life to social service.

> *"I do not look at this as a job. I have dedicated my life to the service of people; it is like a vocation for me." (Karuna, Manager, Private home)*

She had not received any formal training for this position though she had a degree and had taken health and safety training. The manager position was not time bound and did not include the issue of 'transfer' attached.

> *"Management does not change regularly but even if it changes it does not impact on the regulations. We try to run it like a home and hence keep any changes to a minimum." (Karuna, Manager, Private home)*

The manager is someone who the management (the above mentioned association) has a close relationship with and hence considerable trust and discretion in the handling of the daily affairs is placed in the hands of the manager. The selection of the manager is based on past affiliation with the person.

> *"About my selection, they knew me, right, so they asked me to join them. I obliged because I thought it was a good opportunity to serve our grandparents" (Karuna, Manager, Private home)*

The manager's role includes overseeing the entire running of the home which comprises 70 residents. The role is very stressful as she does not have any assistant. This is seen by both staff and residents as something affecting her performance and indirectly the management of the home.

> *"The success or failure of the home is all on the manager. This manager does not have a strong character, she is a little weak, she gets scared. She was very good during her first term but now she is grown old and hence chooses not to*

interfere in the residents' affairs. She is afraid of the residents, staff, everyone. She likes to say yes to everyone. She needs someone to assist her. She consults me for things, just imagine! I am only a low level staff" (Suraj, Staff, Government home)

The staff in the Private home includes 6 domestic helps (including cleaners and laundry men), one cook and a gardener. A majority of them are locals and are largely poor and uneducated, having had no training or experience in the care of the elderly. They have been recruited on the basis of recommendation made by existing local staff. Their average salary per month is between Rs. 1000 (£10) and Rs. 3000 (£30). Besides their salary, they are also provided their meals in the care home. They have a day off each week or in the event of bereavement in the family (where they usually exchange their day off with other staff). The staff mainly works on a day shift from 9.00 am to 5.00 pm. Their work involves cooking and serving food to the residents, cleaning the residents' cottages, washing their linen and helping them with any other personal chores (upon request).

The managerial team in the Government home consisted of a female manager and two male assistant managers. Varying terminologies were used to describe their position, which included, 'incharge' 'manager' 'steward/ess' 'ma'am' 'sir'. None of the three had any relevant training to reach this position; it was based on promotions in various Government jobs they had held in the past, including secretarial and clerical jobs far removed from the care of the elderly and none had received any in-house induction training for their current position. The manager and her team had completed a three year period and spoke of having a transfer any time soon. As important as their influence seems on the standards and daily routines of the home, the team is, nevertheless, responsible to the higher authorities at Head Office and hence have to implement the rules and regulations set by them. The greatest power of the manager was that of being able to transfer residents between dormitories and recommend transfers of residents to another home. 'Anti-Social' behaviour was the usual explanation.

"I speak to them in the office and if they are difficult or quarrelsome, I tell them that this is their last warning and I will report them to the head office and they will be

transferred or asked to leave." (Rahul, Assistant Manager, Government home)

The Government home has 21 staff who work in different shifts i.e. day, afternoon and night. Besides the manager they include nurses, servants/cooks, sweeper/cleaners and a watchman in a hierarchical structure. The majority of the staff were Goan (only three non-Goan) and belonged to either Christian or Hindu religious backgrounds. The Manager, assistant managers, and the nurses belonged to middle or upper middle class background whereas all the lower cadres belonged to the lower income groups. The starting salary of the Manager, assistant manager and the nurses was between Rs. 10,000 to Rs. 20,000 a month (£100-£200 pounds) (they received increment based on experience). The low level staff receive between Rs. 2000 to Rs 5000 monthly (£20-£50 pounds). Besides the salary, all the staff received other monetary benefits and leave/holidays that a Government employee was entitled to (including a pension on retirement). Thus, there was comparative satisfaction with the salaries because the job was permanent and had security attached to it. The recruitment of all the staff was not specifically for the care home but for an equivalent government position (peon, clerk and so on) who were then transferred to different Government departments. The five nurses have received nursing training though were not specifically trained in taking care of the elderly.[14] They do rounds during the medication times i.e. morning, afternoon and evenings. They are addressed as 'sister' and 'brother' by the other residents and other lower staff. Residents who are feeling unwell come to the dispensary and they are given medication by the nurses. In emergencies they are taken to the primary health centre located in the campus or an ambulance is called. The eight servants are the ones in direct contact with residents, serving them, helping them bathe and the like. The four sweepers are responsible for the cleanliness and the watchmen for the security of the home. They are called by their first name by the residents and the other staff. There were 12 staff each for the day and the afternoon shift. The night shift has 4 staff on duty i.e. one nurse, a female servant, a male servant and a watchman. All staff are appointed by Government appointment; a number of casual remarks were made by some staff that the Government appoint these staff based on influence and not

[14] The syllabus on nursing studies in Goa does not include the care of the elderly as a component

merit.[15] Most of them come from lower income groups having received little or no formal education.

In the Religious home, the manager and assistant manager are religious sisters of the order which runs the home. Both are appointed by the Superior General of the congregation. The manager is called the Superior General of the home and both are addressed as 'Sister' by the residents and staff. Their appointment is generally for a three year period after which they are transferred to another project set up by the order: school, orphanage, or another care home. Although possessing a degree and a nursing qualification, they lacked any special qualification concerning care of the elderly. Their duties are more varied and exacting. It is less easy to classify work that has to be done and the constant presence of the manager is required during the performance of different staff roles. There are no clear cut shifts for the manager or the staff. The home is also a home for both the manager and assistant manager. The sisters have no holidays as such, except if they are ill. They receive no salary. Besides running the home the sisters are also involved in a number of religious activities of the church. This is looked at both negatively and positively by the residents. Positively, because the home as a whole gets involved in the parish community life so that the residents play a significant role during important parish functions. Negatively because when the managers involve themselves in church work, they do not find time to spend with the residents; the residents express feeling of neglect as a result. As a result, long hours of work and overwhelming responsibilities were constant concerns emoted by the managers – though not directly.

> *"It has been a long day today. I do not think I sat even once. First training those girls – it's a new batch. Then the constant grumbling of the inmates – I gave them a piece of my mind today and asked them to take up some responsibility in the home; they are getting very lazy. I then went visiting the families in the village. I hardly had time for my meals" (Jeanette, Manager, Religious home)*

[15] A Government job is looked upon as a very lucrative option by Goan people as it provides job security. Cases concerning bribes and influence in getting Government jobs are regularly exposed in newspapers in Goa.

The assistant manager took upon herself the health concerns of the residents. She was a trained nurse and administered medication to the residents, checked their blood pressure, diabetes and carried out other routine health checks. The managerial team emphasised cleanliness, good manners, and presentable dress as necessary etiquettes in the homes. This was ensured in an unduly restrictive and authoritative manner. On one of my field visits the manager was admonishing one of the residents when he came to the dining hall in his shorts and t-shirt:

> *"Is this what your parents have taught you? Go at once and get changed into proper clothes (by which she meant a collared shirt and trousers) and come back." Reggie was having his breakfast and had to leave it midway and go to his room. The manager followed him and showed him what to wear. (Field notes, Religious home, August 2011)*

The lower staff in the Religious home consisted of one cook and four caretakers. The four caretakers (one male and three female) come from remote villages of Jharkhand, Bihar and Orissa[16]. They were recruited directly from the villages. They are responsible for all the needs of the residents. They work from 6.00 am to 9.00 pm with a one hour break in the evening six days a week. Their time off is on Sundays between 15.00 to 19.30. The staff are not only uneducated, but had no training to care for the elderly and lack the knowledge of the local language spoken by the residents which was taken very negatively by the residents. All the five staff are Christians, but never participated in the religious services along with the residents. They receive a salary of Rs. 4000 (£40) monthly besides receiving all their meals and accommodation during their stay in the care home (which is on an average for three years).

Training

In the three care home, no staff at any level were specifically trained in taking care of the elderly. Training was viewed in all the three homes as an optional extra and a way to acquire 'westernised', 'posh' but largely irrelevant skills. Training was not seen as particularly relevant to their practice.

[16] These states are located around 2500 miles from Goa.

The Government staff tended to be in agreement with each other about the dubious advantages of training. The comments below by Government staff were not untypical:

> "*We have taken care of our elderly in our homes always. Why do we need to be trained for that. You are born with it; no written or taught material can teach you that" (Kareena, Staff, Government home)*

The typical comments in the Religious home included:

> *'The nuns have got us here; they have instructed and trained us. We now do as they have taught us. Don't you think that it is enough? It is, right?' (Lata, Staff, Religious home)*

In the Private home, training was not rejected out of hand although it was seen as somewhat peripheral. It was considered a means of self-advancement rather than as having some practical day to day use for working in the homes. This however differed depending on the age of the staff.

The older staff felt that much of this training would be about telling them what they already knew and what they already did:

> *'At the age of 50 what can I do with training, where do I have to go with this training? It will all be wasted' (Kesar, Staff, Private home)*

The younger staff wanted more knowledge to get on with life away from the home:

> *'I would like to go for training if it is organised for us. I can add it to my CV' (Vishanti, Staff, Private home)*

> *'Yes, training is the most important. I am trying to press the management about it every time. Now there is nothing I have learnt after the general nursing course I did around 18 years back. It has all come with experience. Training would be good to expand my knowledge, particularly about the latest issues concerning the old, like dementia, mental health and the like. It could also widen my job prospects' (Deepa, Staff, Private home)*

The division in opinions more or less occurred along age lines across the three homes. In fact the older staff felt that the younger ones could not understand the elderly since they had no experience of life. The management however felt that

employing experienced staff was bad as they might have learned 'bad habits' from the old place they worked in and hence it was better to employ inexperienced staff and 'train them' according to the traditions of the care home.

Ambitions

One of the ways in which staff tacitly expressed their approach to their work was via their job commitments, ambition and reasons for joining. Most of the Government home staff showed their inclination to the work as a lucrative job security.[17] However, some of the Government home staff also had moral motivation (a vocation) for taking up care work in the home:

> *"Well, I feel it is better to do their work rather than to work for 'boro lok' (fit people). Fit people knowingly trouble and harass you; at least these old people do it unknowingly. I feel good to work for old people; they are very nice. Though we have our issues, we sort them out at the end. It is a very satisfying experience." (Savita, Staff, Government home)*

The religious and the Private home staff seemed to be motivated by financial needs and expediency although most felt, when they applied for the job, that it would be a bit better than 'just cleaning'. They had no qualifications and very limited opportunities for upward mobility. There was therefore a limit to the jobs open to them.

> *"Sister (Manager) has got me here from my village in Chhattisgarh. We did not have food to eat. Now I not only get food and shelter but also send money home, which is the most important. I was not sure what work it was, but it is fine." (Raju, Staff, Religious home)*

> *"Our village was very poor and in many senses it still is, as you can see. This home was not allowed to be built in this village as we did not want to destroy the Hindu cemetery upon which the home is built. But the organisation promised firstly a cemetery to be somewhere else in the neighbourhood and secondly more importantly create jobs for all the poor*

[17] A Government job in Goa is viewed as lucrative because of the security and pension benefits attached to it.

people in our village. So we agreed. We were all employed after. We are happy because we can now earn some extra money." (Suraj, Staff, Private home)

The management of the Religious home always felt that they were understaffed and felt that this was the biggest threat to their successful running of the home:

"We get them from their villages, train them and everything. Once they learn everything, they leave. We are left high and dry. They are very unreliable. We cannot afford Goan salaries that is why we need them. Anyways, you tell me, who in Goa wants to work with/for the elderly?" (Jeanette, Manager, Religious home)

The staff work in care homes involves the kind of work that by ordinary standards is distasteful, disgusting and frightening. The exhausting nature of the heavy physical work that is involved in constantly lifting old people is tremendous. The emotional demands are exhausting as well. When I reflected on my data collection phase, I realised that the staff population in all the three homes had remained virtually unchanged (except for one transfer in the Government home), but the resident population had altered. Recalling the residents who died made me realise the transitory nature of the care work and admire the ability of the staff to constantly adapt to new circumstances and cope with loss.

Initiation to rules and regulations of the homes

In the Private home, staff learnt the language and styles of the home through 'short cut rules of homes.' The comments from staff below were not untypical:

'I just hung about and watched during the first week. Slowly I picked up' (Vishanti, Staff, Private home)

'I learnt by watching what jobs were nasty and how to avoid them. For example, I say I am going to help wash up dishes and avoid the ritual toileting washing which I do not like doing' (Shyam, Staff, Private home)

In the Government home too, giving direct instruction were seen as inappropriate

'Staff openly instructing each other is discouraged. He did it to me the other day. I was very upset; it was not his place to

do that. You cannot order people around here' (Kareena, Staff, Government home)

In the Religious home however it was the opposite. The junior staff looked up to the management and other senior staff for instructions from the beginning. The senior staff looked to the management to help them take their decisions

In a general sense the data across all the three homes revealed that the emotional aspect of staff work with the residents was discounted as their jobs were made into a series of tasks to be ticked off at the end of the shift. The accounts reflected on a regulated work ethos: The next section will discuss the rules and regulations in the three care homes in more detail.

4.2.5. Controls and procedures

Controls (*formai)* and procedures (*prokriya)* guided the everyday lifestyle in the three homes:

Admission and Discharge

Admissions to each care home began by filling up an application form (see appendix 7 for example). The care homes are open to all sections of the society, irrespective of religion, caste or creed. There are restrictions on the number/amount of personal belongings that a resident can bring along on admission. Physical examination and cleanliness of residents are invariable rules. If unclean, residents are given an immediate bath.

In the Private home, to be granted admission older people need a valid reason to be away from their homes (family history and background), are above 60 and are in fair health (mentally and physically) according to a doctor nominated by the home (or if personal doctor, a physical fitness certificate needed to be provided). There is a screening body which goes into the family history, the older person's financial capabilities, the dependability of relations in case of emergency and funeral arrangements in case of no family. Once admitted, in the case of serious health emergencies residents are moved to a hospital and the relatives concerned are notified. In the event of the death of a resident, efforts are made to contact his/her relatives at the address available in the records. In cases where the relatives fail to respond to take possession of the body within 24 hours (after the demise), the funeral

rites are performed by the institution. Besides this, a resident can choose to terminate his membership and leave the home by giving three months' notice. At the same time misbehaviour causing a nuisance to fellow members or creating disharmony in the campus entails termination of membership in the home.

The documents needed for admission to the Government run care home are Income certificate, Residential Certificate (certifying that the older people has resided in Goa for 10 years and above), Health Certificate certifying the state of health and/or nature of sickness, and that the applicant is mentally sound, does not suffer from any contagious disease and is fully ambulant. Both male and female residents of 60 years and above are allowed entry into this home. An age allowance of five years is made for blind and handicapped persons. Inquiry of the individual cases is conducted by field staff before admission, and admission is confirmed within 10 days from the date of application. In case of death, some families take the body, otherwise the Provedoria funds the funeral proceedings according to the religious affiliation of the deceased. If the residents cause inconvenience to other residents by their behaviour they are put into the dormitories for the mentally ill as a corrective measure.[18]

The admission requirements in the Religious home include any persons above 60 years in a healthy state of body and mind and with a surety (can be a relative). However the customs and norms of the home including regular Christian prayer services, beef and pork diet and above all a Christian religious management, attracts only a Christian population. In case of demise, if the family is available, they claim the body; if not then the funeral rites are conducted by the home. If any resident is trouble according to the rules and discipline of the home he/she can be expelled. The departure procedures are discussed at length during the admission process.

[18] This placement is time bound – the amount of time depends on the discretion of staff. In one of my conversations with the staff it emerged that residents who cause a nuisance in other homes managed by the Provedoria are sent to this home as a corrective measure.

Fees and facilities

The monthly charges vary between Rs. 2000 (£20) in the Private home, to Rs. 3000 (£30) in the Religious home to Rs. 500 (£5) in the Government home.[19] This charge includes food, rent and cleaning; all other personal expenses including cost of medicines, toiletries, travel, and phone are borne by the resident. In the Government home however, the charge includes all costs. A few places are sponsored by donors and are allotted free of charge or at a subsidised rate to those who are financially poor in the Private home and the Religious home. In the Government home, admission is granted free of charge if the income certificate indicates financial instability.

Rules and regulations on entry

Across all three care homes, the residents are to stay in the premises allocated to them which may be changed at the discretion of the management. In addition, they are entitled to access and use common areas and facilities such as hallways, common sitting areas, library (in the Private home), gardens (in Private home and Religious home), and the like.

Use of narcotics and alcoholic drinks in the premises of all three care homes is prohibited. Misbehaviour (breaking rules and regulations), causing 'trouble' to fellow residents and/or staff and stealing is not allowed. Indulging in the aforesaid behaviours entails expulsion from the care home. However many male residents have spoken about smuggling in alcohol without the knowledge of the staff and management.

Resident wishing to go out of campus for a short duration can do so after entering the necessary details in the register kept for the purpose in the Private and the Religious home. However, this flexibility is not present in the Government home where the locking of doors and constant observation of residents is common. However, on making a request with the management in advance, residents across all three care homes are 'permitted' to stay out for the night with friends or relatives or

[19] The Government of Goa provides Rs. 2000 to every older people in Goa under the *Umeed* (Hope) scheme. The older people in Government home are not entitled to this – which implies that they do pay the same amount as the resident in a PH.

go on a holiday for a period. In the Private home however, if he/she stays out for more than 30 days they may irrevocably forfeit their claim to the accommodation. During the course of such absence, the resident member continues to pay normal monthly charges. Visitors, friends or relatives are permitted to visit the campus during visiting hours, with visits restricted to visitor's space.

To elaborate this section further I will describe how the rules and regulations overwhelm the daily routine of the residents in the three care homes. The routine of daily life is guided by explicit and implicit rules of behaviour which were part of everyday life within the care homes. A closer look at a typical day in the care home will help one detect these.

4.3. Typical day at the Private home

The proceedings of the day at the Private home begin at approximately 6.00 am when the residents walk to the dining hall for their morning tea which is already prepared by the live-in head chef (all the other staff live off premises). This is followed by a short prayer service organised for the residents by the manager. This includes reading passages from the Hindu scriptures and playing religious music. The service is attended mainly by Hindu women, the men in general and residents of other faiths avoid this service. Many residents retire to their rooms and others are seen going for short walks around or outside the campus. According to the daily routine, the prayer service is followed by yoga; it is only those attending the prayer services who take part in this. The manager demonstrates the yoga positions to the residents. At 9:00 a.m. breakfast is served at the tables in the dining room by the staff. Breakfast includes basically Goan savoury items like *'upeet'*, *'shira' 'fov'* and *'puri bhaji'*.[20] The residents need to come to the dining room to have their breakfast. Many residents who come for morning tea choose to remain here till breakfast to avoid the inconvenience of walking another time. The residents need to remove their footwear before entering the dining room as the place is revered. When they enter most of the residents bow in front of the picture of the Hindu goddess and sit at their

[20] The menu for the day is decided the previous night and is written on a big black board in the dining area for the residents to see, hence some of them can get food stuff from the market if they do not like the day's menu. On special occasions people can sponsor meals. This happens very often; breakfasts, lunches and dinners are sponsored by residents and NGOs.

tables. The residents have allocated places (which they need to sit at): sitting at a wrong place can invite a quarrel with a fellow resident or a admonishment from the staff.

The breakfast servings are left on the tables till 10.00. Following this the staff and manager have their breakfast at the same place from the same menu. After breakfast, the staff get involved in cooking. The residents retire to their room. Many residents are seen reciting their prayers. Some watch television in the common room or listen to radio in their own rooms, others go to the market/banks/post office/temples, and some also help the manager with the day's administrative work. Residents are seen sitting on the verandas of their cottages chatting to each other and in many cases just staring and waiting for the next meal time. At around 11.00 am hot water is taken around to cottages by a male staff; residents are seen filling their flasks. This water is used to prepare instant soups, tea or coffee by the residents. Many residents are seen visiting the physiotherapy Centre during this time, yet many others visit the other cottages and share a chat. At 1.10 lunch is served and kept open for the residents till 2.00 pm. This is a routine similar to that of breakfast. After lunch most of the residents take a short nap, some watch television and others read. Many staff join the residents while watching television. The residents eventually retire to their rooms. Afternoon tea is served from 15.30 till 16.30. Most residents watch television after that and then go out and sit in the gardens. The staff, with the exception of the head chef, watchman and the manager, retire for the day at 17.00.[21] A very casual interaction between staff and many residents is witnessed at this point where residents pass on regards to the families of the staff. The residents begin their evening walks at around 17.30 and go to nearby temples. Many male residents go to the local tavernas for a small drink and get back and go straight to bed. Others share chats with each other, bathe, offer *puja* (prayer offering). Many also help the manager with the evening's administrative work. There are some family and friends visiting during this time. The residents assemble to watch television at around 19.00 and enjoy the regular soaps. The men however get together separately and discus current political issues. Dinner is served at around 20.00 by the residents themselves.

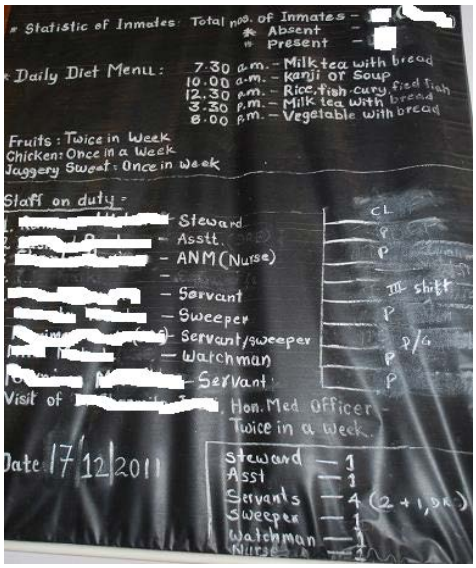
[21] The staff in the infirmaries have night shifts.

The head chef heats the food and retires. Any gesture by the head chef to serve the dinner provokes resentment and retaliation by the residents. The men keep the dishes ready while the ladies serve food. After dinner the men collect the dishes and store them aside. The infirmary staff and the manager come along for their dinner at 21.00. Some of the residents watch some more television, others retire to sleep. The common area door is closed at 10.00. The residents retire to their own cottages which they can lock. This separation is seen as a good thing for the residents to have some privacy, dignity *(mann)* and sense of ownership. However, in the event of any emergency this could be a problem. There is a phone outside the cottage, which is connected to the main area; in the event of an emergency this phone could be reached to alert the manager. This is not always successful particularly in cases where the residents because of their physical or cognitive inabilities at a particular point were not able to use it like in the case of Manju and her roommate described in chapter 9 (see page 229).

4.4. Typical day at the Government home

The morning begins when the chef comes in to prepare the tea at 6.30 a.m.; the other staff come in between 7.30 and 8.00. The morning tea is served to the residents at 8.00 am in the dormitories. They are also given two and half bread rolls each; one for breakfast, half for evening tea and one for supper (see figure 4.5 below). Staff have their favourite residents for different reasons such as similar caste, community, language. These favourite residents are often given extra bread roll and other food. This has often sparked big confrontations in the home. Following this, the residents have free time. However, there are no leisure/ recreation/educational activities on which to spend their time. Hence they are seen sleeping/sitting in bed, standing on the veranda and keeping a watch on who is coming and going. A couple of residents are seen chatting/discussing/singing together in dormitories. The women and men are supposed to keep to their own floor and any interaction between the two is discouraged.

Figure 4.5: The display chart in the Government home



At 10.00 am, the midmorning meal is served – the meal alternates between *canjee* (rice gruel) and soup throughout the week. Soup is popular among the Christians whereas canjee is more popular among the Hindus. Many residents were seen taking the servings and then emptying them into the bins; some grumbled about the taste but eventually ate it and some others grumbled about how people do not value food. If the meal was served by a member of staff who had been hostile to a particular resident in the past, the food was not taken or else it was taken and thrown out.

From this point on residents are seen waiting again for their next meal. On my first day at the home I asked Alice casually what her plans for the day were. She replied:

> *"There is nothing to do here. All I do is wait and wait and wait till they serve us breakfast and then I start waiting and waiting and there is lunch and this wait goes on till evening tea and dinner and then I am locked up." (Fieldnotes, Government home, August, 2011)*

Following this, residents would continue waiting for lunch which would be served at 12.30. At this time a bell is rung signalling for the residents to gather in the dining area with their plates. The residents are seen to be almost mechanically responding to the bell and gathering in the dining area. As they queue up to be

served, the staff tends to queue first to take plates to the infirm and mentally incapable residents; the men queued second followed by the ladies. After getting served the residents return to their respective dormitories to eat their lunch there. They sit on their beds to have their lunch.

When all are in, the dormitories are locked. The staff do not have the same lunch; they bring packed lunches from home and eat them in groups. These groups among staff are formed on the basis of some common element that they share such as religion, caste, and language. The norm after lunch for the staff is to retire for an afternoon siesta. They wake up at 3.00 pm and tea is prepared. At this point all the six dormitories are opened. The mentally ill patients are seen roaming around the veranda talking to themselves, singing loudly or dancing. Many of them are seen talking to the able residents and asking them for cigarettes or alcohol. There is an aura of chaos around the home at this point. Tea is served at 3.15 p.m. Residents who are on the bath rota for the particular day are given hot water for a bath at the same time: the residents take bath every 2 days. There would be quarrels between residents or between staff and residents regarding bath or tea. This would be the topic of discussion for the entire evening among some of the residents. Other residents discuss various things, particularly issues surrounding the staff. The dormitories are the places where the discussions build up. Many a time these discussions lead to silent protest among the residents; for instance refusing to have supper. The staff however remain unaffected in most cases.

At 4.30 supper is served; an aluminium bucket of vegetable gravy is taken around the dormitories and as the residents hold out their bowls, plates, or cups the gravy is poured into them. After this at 5.00 the doors of the dormitories are locked and most of the day staff leave. The night staff come in eventually. The doors of the dormitories are opened in the mornings when the staff come in to serve the morning tea.

4.5. Typical day at the Religious home

A typical day at the Religious home begins at 6.00 am when the staff begin preparing breakfast. Some of the residents are seen walking to the nearby Church for mass, some pray in the chapel and yet others enjoy some extra sleep. A bell is rung by one of the residents to alert fellow residents for breakfast. This is also done at

prayer times and other meals. Breakfast is served by the staff at 8.30 am; residents are seen seated at their places waiting for it. At this time the assistant manager gives the morning medication in small containers to the residents. This is followed by breakfast which generally is bread/chapatti with pulses/proteins. The residents finish their breakfast and leave the plates at the wash basin. The staff do the washing up. Residents help each other to collect plates and cups; at the same time some residents are seen washing their own dishes. Following this, some of the residents help with the kitchen work like cutting vegetables and cleaning rice. The others take a walk in the garden, read the newspaper or watch television. If the barber has a round, then the male residents have a haircut or a shave. These activities continue till 11.00 am when mid-morning tea is ready in two big pots and is placed on one of the dining tables. Leena, one of the residents, helps in serving tea to all the other residents wherever they are seated. There are no exchanges of words during all these activities; it is very mechanically followed.

At 11.30 am, residents are seen gathering in the chapel after a bell for an hour long prayer service. All the residents have to join in the prayer service except if they are ill and have got permission from the manager to stay in bed. The prayer is followed by the residents walking to the dining room and seating themselves for lunch. Proceedings similar to breakfast are followed during lunch time. Lunch includes rice, curry and a vegetable/meat/fish side dish. After lunch all the residents go to take a nap until 15.00. One of the residents, however, stays behind to help the staff with drying the plates. When asked about it, he says that he has been doing it for the last 10 years he has been there; by now it has become a routine for him. He also mentions that he likes responsibilities. At 15.00 pm hot water is available for a bath which is poured into the residents' buckets by the staff. With the exception of three residents, none of the others need assistance during bath. Afternoon tea is served at 16.00 with a Goan home-made sweet. After the evening tea, residents go for a walk around the village. Women go to visit friends in the village, men gather with other village men at the village square to discuss issues. A couple of residents are seen playing cards at the dining table. Members of the village, young and old, come to visit the residents and chat with them. Residents have to gather in the living room at 19.00 to recite the rosary. A roll call of the residents is taken by the manager after the

rosary. Dinner is served at 19.30 and a similar routine to lunch and breakfast is followed. Dinner includes bread with two side dishes (meat and vegetable).

After dinner the residents play cards for around two hours. There are some interactions between residents at this point; many important issues and frustrations of the day are discussed. However, this is not a regular phenomenon; there are times where the residents play for the whole two hours without saying a word even about the game. The residents are not encouraged to enter the living room area after 21.00; the manager and the staff consider this their own recreation time. The manager does not seem very supportive of residents' playing cards and expressed this subtly a number of time during my observation phase. However, the residents did not react and continued playing till around 10.15. Lights are switched off by the manager at 10.30 and residents retire to bed. The manager occasionally does a round of the rooms between 11.30 and 12.00 to check for any problems. There are no alarms for the resident to call staff in case of emergency; however, the manager feels that the strategy of accommodating two to four people in each room serves the purpose of an alarm.

Various themes kept emerging from the above discussion. These included autonomy (*aplo adhikar),* control (*formai),* and resistance (*virodh).* All these themes were probed further through observations and interviews which have formed a major part of my analysis and form the structure of the next five chapters.

4.6. Socio-economic demographics of respondents

I will now give an overview of the respondents who were interviewed. An understanding of this is important for the purpose of analysis. The sample size of the interviewed respondents included eight residents and four staff in each care home (besides the managers who were interviewed during the scoping study) (see appendix 8 for respondent data).

4.6.1. Staff

The four staff (three female and one male) from the Religious home were all uneducated, between 20-25 years of age, Christian and had been in the home for the last 3 years. From the Government home, three lower level staff and one nurse was interviewed (2 male and 2 female). The lower level staff were uneducated and the

nurse had completed a diploma in nursing. Three among them were Hindus and one Catholic. All the staff had completed between 5 to 10 years of service in the home. The staff interviewed from the Private home were all Hindus and had completed between 7 to 15 years in the home. They were aged between 30 and 40 (two female and two male). These respondents were not randomly selected. Attempts at purposive sampling were made i.e. to reflect the varied composition of staff. However, as indicated in the methodology chapter (see page 54), not all the staff agreed to the interviews, hence, I had to settle for those who were willing to talk and at the same time represented the wider picture of staff composition.

The sections below presents the socio-economic profile of the residents in each of the care homes in terms of age, number of years at the home, gender, religion, education, employment history, payment options, marital status and family support.

4.6.2. Residents

As evident from table 4.1, a majority of the residents interviewed were below 80 i.e. the young old; they had the capacity of determining their own choices. As noted in the previous chapter this was the population who were a focus of my research. With regard to the number of years spent at the home, the vast majority of the respondents predictably spent between 5 to 15 years in the homes. This points to the ability of residents to speak about their experiences over time. In terms of gender, although the table represents an equal number of males and females, the reality in the homes does not reflect the same. That is, there are more women than men in care homes.

Table 4.1: Age, number of years in the home and gender of the residents

Age groups	Government	Private	Religious
65-70	6	2	3
71-5	2	4	2
76-80	0	2	3
Number of years in the home	Government	Private	Religious
5-15	8	8	7
15-25	0	0	1
Gender	Government	Private	Religious
Female	4	4	4
Male	4	4	4

As for religion (illustrated in Table 4.2), Christians are in a majority in the Government home and Religious home, i.e. 63% and 100% respectively. However, in the Private home 88% of residents are Hindus. Although the majority of Muslims in Goa come from a poor economic background, there were no citizens from this community living in a care home as far as I could ascertain.

Table 4.2: Religion of the residents

Religion	**Government**	**Private**	**Religious**
Christian	5	1	8
Hindu	3	7	0
Muslim	0	0	0

From the sample of residents in the Private home it was found that the large majority, i.e. above 80%, was literate, mostly graduates and had held white collar jobs in the past including teachers, doctors and accountants. A majority of the respondents from the Religious home knew how to read and write. 50% of the respondents interviewed worked on daily wages however a considerable number i.e.

25% have also held white collar jobs. In contrast, the respondents from the Government home were less educated and unemployed or engaged in menial labour in the past. As such, the majority of the respondents paid for their health care in the Private home and Religious home. However, in the Government home the majority lived free of charge. Table 4.3. demonstrates the three characteristics.

Table 4.3: Education, employment and payment options of the residents

Education	**Government**	**Private**	**Religious**
No formal education	6	1	2
Secondary School Certificate (High School)	1	1	3
Higher Secondary School Certificate (A levels)	0	0	0
Graduate	0	3	2
Postgraduate	0	3	0
Tertiary	1	0	1
Employment	**Government**	**Private**	**Religious**
Unemployed	1	2	2
Daily Wages	7	0	4
White collar	0	6	2
Payment options	**Government**	**Private**	**Religious**
Paying full	3	7	6
Paying subsidised	0	0	1
Free	5	1	1

In the sample of the three homes there was a difference in the respondents' marital status and family composition. In the Government home the majority i.e. 63% of the population were single, however in the private and religious the majority were widows/widowers. Family composition was important to ascertain, in order to have an overview of the level of family support that might be available to the older people. The majority of the respondents in all the three homes had children/relatives,

though the figure was comparatively lower in the Government home as illustrated in Table 4.4.

Table 4.4: Marital status and family composition of the residents

Marital Status	**Government**	**Private**	**Religious**
Single	5	2	5
Married	0	1	1
Divorced	2	0	0
Widow/widowers	1	5	2
Family	**Government**	**Private**	**Religious**
Siblings	2	0	3
Spouse	0	1	1
Children	3	6	3
Destitute	3	1	1

4.7. Conclusion

This chapter provided demographic and background information about the homes, the residents, and the staff members who are part of this study. The above snapshots served as a backdrop for the qualitative findings which are presented in the following five chapters. As indicated, participant observation and interviews conducted with residents over an eight month period constitute the primary data upon which the following chapters are based. Data gathered from interviews with the staff and management are also included to supplement the findings from the interviews with the residents. In essence, many of the themes that emerged from the interviews with the residents were similar to the staff's perceptions of the residents' experiences in the home. Thus, the staff's quotes are used only to supplement the findings, in order that the residents' voices might be heard.

The framework in the following chapters follows more or less a chronological order, according to their place in the residents' accounts of their experiences. This order allows for a natural progression of the themes that reflects the experiences of the residents as they encountered various aspects of the process of institutionalisation

and the meaning this process entailed for their lives. Arranging the constructs in this order allowed me to put together the different themes like a bricoleur using the theme that followed a course of natural progression (Denzin and Lincoln, 1994; Levi-Strauss, 1966). This enables the formation of a bricolage of categories that facilitate an understanding and interpretation of the phenomenon under analysis – in this case, institutional living of older people (Denzin and Lincoln, 1994). The goal is to allow a complete picture of the residents' experiences to emerge, theme by theme. Becker (1978) likens the process to the image of a mosaic in which each theme, as it is added, enhances the understanding of the total picture. Ultimately, this structure helps me tell a more complete story of the residents' relationship with care homes which began with their decision to enter the home (in their pre-entry phase) and will end with their death or leaving (in the exit phase).

This framework (of natural progression of the residential career of an older person) can be problematic as it assumes a normative construction which is unilinear, beginning with pre-entry and ending with exit. It does not consider the deviations that may occur in this sequence as a result of the care home's closing down, or re-entry of the older people after hospitalisation. This progression also takes for granted the sequence of events as occurring homogenously across the homes and residents. However, the possibility, although slim, does exist for the sequence to vary in the case of some residents or some care homes (as in the instances above). Secondly, this structure does not follow the same resident from entry to exit. The data on exit came from second hand information or something they imagined may happen in the future, or something that came out as a result of discussions with the staff and fellow residents as opposed to the earlier phases where the data were collected (from research participants who were being observed or interviewed). Thirdly, this is not a longitudinal study, hence not all phases will be equally strong in terms of my fieldwork because of the inherent differences in the access I had to them. Most of the residents had undergone several phases of their residential careers, so my data of the initial phases relied on their memory of the initial phases, which may not be complete or may be inflected with their current purposes in retelling the story to me. For example, in the post-entry and in some of the cases the entry phase, I was a participant observer in the field where I could observe the details of everyday

activities. I used interviews to supplement and verify my observations in these phases. However, in terms of the pre-entry phase, I had to rely only on the interview accounts from the residents and in the exit phase, as emphasised in the previous point, I relied on second hand information. Hence, this structure has inherent methodological problems.

These shortcomings, however, do not undermine the objective of my study which is an attempt to understand the experiences of the residents in care homes. The voices of the residents are very powerful in echoing these experiences even if they have occurred in the past. Participant observation and interviews with the staff and management helped me to corroborate data received from the residents during their previous phases and in a way helped to minimise the residents' purposeful echoing of narratives. In terms of the exit, this was the best available method to develop the arguments around leaving and death. This aspect has an overwhelming presence in the accounts of the residents. Expanding the study to three homes allows me to validate and compare the accounts with residents across the three homes and an exposure to more comprehensive data. Thus the structure, though problematic, is the best representation of residents' narratives as presented to me.

Chapter 5: "They decided to move me here": Coming into a Care Home

5.1. Introduction

> *"I would never be here if my husband was alive. His death (mornon) changed my destiny. My children did not have time to take care of me, hence, they brought me here…" (Madhuri, Resident, Private home)*

Older people seeking residential care form a very small minority of the older population in Goa. However, the trend has seen a dramatic rise in the recent years as described in the introduction of this thesis. How do older people in residential care comprehend this move? The narrative of residents as reflected in the above quote can be read as a story representing lack of choice (*iccha)* and autonomy (*aplo adhikar).* In this chapter I seek to find out the different reasons that led residents of this study to enter residential care and to understand the preparations that they underwent before they entered – thus reflecting the pre-entry stage of the older person's residential career.

The experience of moving into the three care homes was explored mainly from the perspective of those with first-hand experience, that is, the 24 residents I interviewed. As such, the narrative of the individual encompassed not only the experience per se, but also iterations and interpretations of that experience over time. Any narrative is a product of all the personal biases that function to shape a coherent and acceptable view of oneself and one's experiences (Young, 1998). However what is remembered or recalled for an interviewer can say as much about the present as about the past. It is also likely that interviews with family members and relevant others would yield a different perspective of the process of moving and might have revealed different aspects. The limitations of interviewing the above have been discussed in Chapter 3 (see page 72 and 73).

In this chapter, I will begin with a broader theoretical discussion on changing family system and older people moving into care homes. In the following sections I will then analyse two specific aspects of moving into the three homes I studied: the decisions and factors contributing to the move and the preparation for this move.

Each section will be explored and analysed within a theoretical framework and relevant data from fieldwork while drawing out their implications for my study.

5.2. Changing family system in India

The process of becoming a resident may centre on a set of events which occur in quick succession, or may be traced to an accumulation of changes which undermine the individual's ability to live at home (Peace *et al.*, 1997; O'Neill *et al.*, 1988). Various researchers in the west studying older people's admission into care homes have considered a variety of reasons to be important in explaining this move. Many of the reasons have to do with the changes which both the older people and the society as a whole are experiencing. These included physical inability to continue living independently, various losses of relationships resulting in an inability to cope, and the inability of responsible others to offer care (Clough, 1981; Tobin and Lieberman, 1976). The arising implication points to the admission of older people into care homes in a state of dependency, feeling demoralised and rejected (Wiersma, 2007). Wiersma evinces how acknowledging that one is going to enter a care home is a key factor in the apathy within the home, that is, the entry confirms the perception of oneself as an individual without valid social roles. Thus, in this case the inability to perform roles such as a breadwinner, the loss of a supportive relationship, and deterioration in physical and mental ability can each be seen by the resident as a sign of failure. The resulting outcome is stigma attaching to the older people and care homes as illustrated in detail in Chapter 2 (see pages 22-24).

The above discussion provided a good basis for developing a framework within which I could examine the factors leading to older people's entry into care homes. However, these studies are limited to the Western understanding where negative attitudes to aging have declined. An understanding of that is definitely important, however, my study being based in India, there is also a need for admission in care homes to be examined against the background of the unique sociocultural context of India. Though this is an under-researched area in India because of the newness of this phenomenon, inferences from the changing family system will be used to further develop the framework for this chapter.

As noted in the literature review, the traditional structure of society in India has emphasised the role of the family in caring for the aged. Thus the responsibility

of providing care was performed predominantly by the joint family (Devi and Murugesan, 2006). The family structure was patriarchal and the oldest male member controlled all social and economic affairs. Correspondingly, the senior female member 'exercised authority in all household matters and influenced general matters as well' (Bhat and Dhruvarajan, 2001:626). The joint family also operated as a micro social security system. According to Gangrade (1999:37):

> "…[T]he joint family performs the tasks of national insurance, guaranteeing basic subsistence to all: the orphans, the disabled, the aged, the widows as well as the temporarily unemployed".

As the above quote rightly suggests, part of the value system of traditional society was the veneration of elders. The Hindu religious scriptures proclaim: *Mathru Devo Bhava, Pithru Devo Bhava* (Mother is God, Father is God). Taking care of parents in their old age is considered a sacred duty of children which is represented in the robust intergenerational contract as argued by Croll (2006). Failing to pay back (taking care of the parents in their old age) according to the scriptures, would result in *Pithru Rina* (Filial debt) which in turn would have dire consequences in the after-life for the children. Collard (2000) supplements this argument when he speaks of the robustness of the intergenerational contract in Hindu India where those who fail to fulfil their side of the bargain can be sanctioned in after-life. In fact, Hindu religious literature, the epics, folklore and tradition, all reflect this value system (Bhat and Dhruvarajan, 2001).

Indian society is undergoing rapid transformation under the impact of industrialisation, urbanisation, technical change and globalisation. Consequently, traditional values and institutions are in the process of adaptation and erosion, resulting in the weakening of intergenerational ties that were the hallmark of the traditional family (Jeffery, 2014). Push factors such as population pressure and pull factors such as wider economic opportunities and modern communication cause young people to migrate, especially from rural to urban areas (Jamuna 1998). Work place not always being close to home, the joint family is disrupted and family ties loosened. Female participation in economic activity alongside men has increased considerably in the recent past (Bhat and Druvarajan, 2001). These developments have implications for elderly care. On the one hand, working couples find the

presence of old parents emotionally bonding and of great help in caring for their own children. On the other hand, high costs of housing and health care are making it harder for children to have parents live with them. This is true both in rural and urban areas. As the National Policy on Older Persons (1999) puts it:

> "Due to shortage of space in dwellings in urban areas and high rents, migrants prefer to leave their parents in the native place. Changing roles and expectations of women, their concepts of privacy and space, desire not to be encumbered by caring responsibilities of old people for long periods, career ambitions, and employment outside the home implies a considerably reduced time for care giving." (Government of India, 1999)

Thus, the changing economic structures, increased mobility of people, changing attitudes and increasing numbers of dual-career families are undermining the capacity of the family to provide support to older people and are weakening the traditional norms underlying such support (Kumar 1997). Bhat and Druvarajan (2001) speak about the changes making single older people (unmarried, separated and widows) particularly vulnerable to poverty, inadequate care and neglect in old age. Single older people according to them are more vulnerable in old age as few people are willing to support non-lineal relatives. Furthermore, abuse and neglect in families, though under-reported, is increasingly present in families in India (Patel and Prince, 2001). Thus, in view of the decline in home-based care, abuse and the lack of an adequate social security safety net, care homes are seen as the only alternative for accommodating the increasing number of older people facing abuse and lacking home-based care. The fall out is the stigma attached to moving into a care home because of the higher magnitude of societal disapproval attached to the absence of home-based care (Prakash, 1999). As described in chapter 2 (see page 23), Goffman (1963) articulates how the departure from the ordinary and normal, in this case living with one's family, is discrediting and the older person or the act of moving into a care home is reduced in the eyes of others – thus acquiring stigma.

However, Cohen (1998:103) notes that 'since the 1970s, gerontological writing in India has been dominated by a powerful and seldom challenged narrative of the decline of the joint family and the consequent emergence of old age as a time of difficulty'. The above comment supports Cohen's myth of a golden age, during

which people never experienced old age traumatically because of the existence of family support systems (Cohen, 1998). Most of the literature on the family in India is confined to glorifying the joint family as a unit that bore the responsibility of taking care of the aged, whilst ignoring the authoritative and oppressive tendencies of the joint family which resulted in phenomena such as the presence of a large number of single older women specially widows in Varanasi (Chatterji, 2000; Cohen, 1998; Owen, 1996). This is also supported by the existence of institutions for the care of destitute older people such as *'Venkatagiri Chaultries'*[22]which have been in operation since the early 18th century (Nair, 1995).

Furthermore, Shah (1998) points to the association between nuclear families and individualistic tendencies as a myth. He claims that nuclear families may arise as a result of a demographic accident[23] or a separation from the parent as a result of the development process.[24] Rajan and Kumar (2003) support the argument and extend it to encompass the idea that support from the younger generation may also be provided in the absence of the joint family. Croll (2006) addresses the widespread fear of modernisation facilitating individualism in India. This relates to the dilemma that young couples face between wishing to invest heavily in their own children and their obligation to repay their debt to their parents. She argues, however, that people are reinterpreting and renegotiating the intergenerational contract, which becomes increasingly based on the benefits that accrue to all the parties. Was this true for older people in my study? The finding of this chapter will attempt an answer to this question.

In line with the above literature, I set out to point to the circumstances under which residents in my study entered care homes. I will use the above framework revolving around the changing family system in India to answer the following questions:

- What are the reasons that led respondents in my study to enter the home?
- Who made the decision for them to enter the home?

[22] Institution for the care of the old
[23] This implies conditions in which an individual's parents have died and he is the only child of his parents who has no child
[24] This implies movement of the individual as a result of economic benefits to him as well as the parents as separation does not imply cutting of ties or individualistic nature.

- How did they prepare for this move?

This chapter sets the ground for helping to understand the reasons, decisions and preparation for entry. It is divided into two parts: in the first part I demonstrate the reasons for the move and illustrate the locus of the decisions to enter the care home, and in the second part I describe the preparation for the move. Throughout the chapter I pick out themes to demonstrate the wider attitudes to ageing and care homes in Goa, India.

5.3. Decision to enter

The locus of the decision to enter the care home is very important for an older person as this move heralds the end of living in one's own home environment (Peace *et al.*, 1997). This decision involves personal trade-offs: personal care versus personal neglect, security versus privacy, company versus solitude, warmth and regular food versus familiar places and objects. It is the older persons who have to balance these trade-offs in such a way as to support their own identity and wellbeing (Peace *et al.*, 1997). In this section I describe the entry reasons and decision of the residents I interviewed across the three homes. If the decision were taken by someone else, how was the older person informed about it? If the resident made the decision, why and how did s/he arrive at it?

A range of situations, events and circumstances were described to me to explain how they came into the home. This included: bereavement; concerns about health; poor or unsuitable housing; inadequate or unsatisfactory care or a breakdown in care arrangements at home; and other people's concerns and anxieties for the wellbeing, safety and protection of older people. Hence the move had most commonly come about as 'a last resort' and 'a last minute option' with no time for the residents to prepare themselves for this move (Bowers *et al.*, 2009). In addition my findings also reflected the move into a care home as a step taken under pressure from family with limited personal *iccha* (choice) manifested for the older person in making this decision. The most common reason was that older people described being perceived as unable to manage the risks and responsibilities which follow from their decisions – for instance, to stay at home – and hence they were denied the right to do so.

All of the 24 residents interviewed mentioned inability, or the fear of inability, to cope in the future as perceived by themselves or their families as one of the reasons for their entry. Some of the terms used to describe this included 'frail' 'danger to self' 'unable to cope'. An inadequate support system was noted also as another popular reason. Except for two residents, all mentioned breakdown of the existing support system which included 'breakdown with some member of the household', 'death of a spouse', 'moving away of family member', 'abuse by family members', or 'changed expectation of family members'.

From the interviews which I carried out across the three homes, only a minority of residents (6, n=24) described a positive choice to enter the home; one each from the religious and Government home and four from the private home. For the majority, the decision about moving into the home was taken by families, in one case a neighbour and in three cases the local parish priest. Almost all the residents mentioned lack of independence and self-maintenance, that is, if they were helpless and incapable of walking, talking, feeding or cleaning oneself, then it would justify entering residential care. This helps to explain the reason for some of the residents agreeing with the decisions made for them to live in a care home as a result of or fear of limited physical/functional capacities. However there appears to be almost universal antipathy towards care homes which centres on the importance of maintaining the self in a particular context and setting which may compromise identity. Another reason to this aversion was the stigma *(dagg)* attached to care homes in India as noted in the theoretical framework. They are seen as places for the destitute old. This *dagg* was seen as an attack on the resident's *osmitay* (identity) – as a result of abandonment by family attached to the entry. In the following sections I will illustrate the accounts from interviews in all three homes and their reasons and decision to enter the home. The accounts are categorised under two sub-themes which emerged from the analysis of data on reasons for entering the home – decision by the resident and decision by others.

5.3.1. Decision by the resident

Feelings of loneliness and frustration, longing for company, health problems, and lack of security in their living environments cause some older people to seek institutional care (Ara, 1995). As noted in the theoretical framework in the beginning

of this chapter, various Western scholars have studied this process and have evinced how the inability of older people to cope in their own homes, the death of a spouse, abandonment, an inadequate support system and other losses experienced by older people (physical and relational) contribute to factors that led to admission of older people into care homes (Clough, 1981; Wiersma, 2007). At the same time, scholars like Ramamurthi and Jamuna (1997) and Ara (1995) have shown the various classifications of older peoples who seek institutional care in India:

1. Older people who live alone; a widow or widower; and couples who are financially sound and have regular income, are either childless, or their children have migrated to other places.
2. Older couples without children who are not in a position to live by themselves due to insufficient income.
3. Older people who are unable to bear the mistreatment in the family of their children.

In the process of analysing my data, I was able to locate residents into one or the other categories mentioned above. The accounts by residents illustrated below contributed a narrative to these categories:

Laxmi who chose to move into the Government home five years back spoke about her decision to enter:

> *"I came here like a mad person because I had nowhere else to go. I was sick and weak and nobody to look after me. My husband had left me….this is the only care home I knew of as it was around my area so I came and I begged the manager for a bed in this place…I was desperate…she told me to go to the head office and fill out some forms and they would then process the application. I told her I am feeling very ill and do not have any more strength to carry on and neither do I have a place to go to in the meantime….I cried a lot and begged her she eventually agreed…I did the formalities the next day"*

Laxmi's decisions to enter the home was based on her desperate need to be assured of her basic needs. The lack of *iccha* (choice) she had in the absence of the family was evident from the fact that the Government home was the only option she felt she had left. Leena had a similar situation

> *"I am a very timid person. People in the world today have changed from yesteryears where people used to help and be there but now even if you ask for help they say no. The result*

is that people lose hope in life and only ask for death, before old people never asked for death. So I was very scared to think of living by myself when my parents died. I was scared to even think of moving into my relative's home as who would hear their taunts about my decision of staying unmarried. Secondly I did not want to go into a home as I like to eat lots and move around and people told me that all this would be restricted. But I had a good friend who told me and tried to convince me; she told as I keep growing old I will eat less and would not want to move out much. She also directed me to this place. So I convinced myself and came here." (Leena, Resident, Government home)

Arjun who surveyed different homes and then chose to live in the Private home said:

"I was a school teacher, a freedom fighter and an excellent father. I have educated my three daughters to the highest level and got them married. I thought I had done my bit for society. Besides I am getting a big pension. I could have afforded home care but I chose not to because I was not sure of the future. My daughters did not support my decision but I was not sure of what they would say in the future. I therefore wanted to take a decision before it was too late. I decided to move into a home where I would get my meals and shelter, yet I would have the freedom and independence to do what I want. The main reason was I wanted continuity to this scenario. I surveyed different homes in Goa and then selected this one. I am happy here."

Felix, from the Religious home was faced with a different situation. He was asked to move out by his family as he was the only one unmarried and the only available option according to him was entering a care home.

"I have my ancestral house but you know that saying right 'Eka lognak bara bandvodi' meaning 'many grooms to marry one bride'. In the same way this house has lots of issues. There are many people who are fighting for a right towards that house……To avoid all this, my brother and I had bought the Candolim (place in Goa) house and used to live there with his family. I fell ill and there was no one who could take care of me in his family. The worst thing was that in three days' time they asked me to leave the house. Imagine, in three days' time! I could not even stand properly but I did all my packing. After that with my bags I went to the parish priest, he knew me, to help me with getting me admitted in that Siolim (place in Goa) home. He tried but there was no place so he told me to come in one month. Here they are not allowing me for days; where will I go for a month? So I told

him, so he spoke to the nuns there and they told me to go here so I came here with all my things on the same day"

The accounts from residents across the three homes illustrated above highlight a number of issues impacting on the older people's decision to move in a care home. Firstly, though a few residents like Arjun point to their move as a preferred choice, the majority of the residents who made their own decision perceive the move as a last resort. The above accounts show that security and regular food are given precedence over privacy, solitude and familiar environment. Secondly, as seen from the literature reviewed at the beginning at the chapter, single older people – widowed, separated or unmarried – feel additionally vulnerable. As a result they find it legally, socially and morally challenging to stake claims on simple issues regarding their own basic rights like ancestral property and, hence, in most cases are left destitute, with moving into care home being the only option. Thirdly, the fact that even as retired older persons, Felix and Leena felt vulnerable when their support system began to break down, contributes to the on-going debate about the inadequacy of the social security system for older people in India. Finally, it did not matter to the majority of the residents in the above cases as to which care home they would be going to; they simply wanted an alternative arrangement which came in the form of the care home they were admitted into. The three points highlight the absence of any additional social security provision in Goa to enable single older people to continue living an independent life, thus leaving entry into a care home as their only option.

5.3.2. Decision by others

Interviews with residents also revealed that many of them were not involved in the decision about their move into the care home. Fatima, for example, was brought to the Religious home by her family. She had no idea she was coming to a care home; her family told her that they were taking her for an outing.

"I didn't make this choice (iccha) – I think I would have said I wanted to stay at home if anyone would care to ask. They bullied me and got me here. I just came with the clothes I was wearing. It has been 8 years and I am still angry, I have refused to see any of my family members."

Residents from the other care homes also expressed the absence of *iccha* (choice) in moving into the home:

> *"My children thought this move was best for me after my husband's death. I just went with their decision. They know what is best for me I guess. They were in a hurry to go back to their jobs, so they decided these things quickly and got me shifted here. I did not even know what was happening. It was all too much for me." (Carmen, Resident, Government home)*

> *"After my parents died, my siblings thought of selling our house. I did not want to and stopped them; they threatened me. I was old. I could do nothing. And since I was unmarried, they decided that I go into the care home. My opinion was not really asked but they are paying the money for me here, so I think it is only fair." (Alice, Resident, Government home)*

> *"I came here eight years ago. At first I didn't know this…my daughter one day told me that it was difficult for them if I stay at home and that she had enquired in a number of homes and found this one most suitable for me. I have not seen her since she put me in." (Valerian, Resident, Government home)*

The above accounts indicate an entry that is clearly based on an arbitrary decision taken by the family over which the older person had no control. Nilu from the Government home had a similar experience but she was still in too much of a shock to narrate it. A staff present there told me:

> *"Nilu's son forced her into the home and then abandoned her. He has not visited her for the last six years. She keeps waiting for him." (Savita, Staff, Government home)*

Gopi from the Private home has eight children who are well settled. They decided to move her to this home. She said:

> *"They decided that I should move to this home. They know what is best for me, so I agreed to go with them."*

Though Gopi accepted her admission, she found it difficult to accept the fact that her children decided to move her into the home. Her contention was the intergenerational contract they shared which she perceived her children had broken. Similarly, the experiences of Nilu and Valerian are influenced by their traditional Indian values, spoken of in the literature above, where parents are to be looked after by their children. This in turn makes it difficult for them to accept the reality of their situation. The fact that they were not involved in the decision added to this difficulty.

Being involved in the decision and giving time to come to terms with the decision would have potentially yielded different responses from Valerian and Nilu.

On the other hand Sheetal from the Private home has a different experience. Her decision to enter the home was the result of the abuse she suffered.

> *"I was made to do a lot of work. I did not mind it because they were my own children. But there were constant taunts and bad words heaved upon me. I forget things and do not remember so they started hitting me, even the grandchildren. I was shifted from one son to another and at last moved here."*

Julian from the Religious home blamed his daughter-in-law (DIL) for all his present woes. He felt he was in the care home because of her:

> *"My son was an angel he cared about us a lot. We got him married to this girl who was a Satan. …….. We brought him up with so much difficulty and never deprived him but he listened to her and disowned us. He threw us out of the house. Our parish Priest asked the nuns here and kept us….."*

Abuse from a family member was cited by other residents too:

> *"Who will listen to her (DIL) khit pit (grumblings), and when my son supports her it is even worse. They have even hit me at times. So it is better here. They used to hit me as well" (Rajan, Resident, Private home)*

> *"Rather than being at your children's mercy, it is better to be here where if you follow rules and regulations nobody interferes. At home my family used to create situations to cause trouble. They also verbally and physically abused me." (Mary, Resident, Religious home)*

> *"I was basically a servant in the house….my brother's kids hit me and called me mad." (Alice, Resident, Government home)*

For Sarita, it was her husband who had taken the decision before his death:

> *"I have always been a very reserved person, never able to speak for myself. My husband was aware of this. Hence he decided to shift to a care home. I did not want to, but he felt if I stayed at home and if something happened to him, I would be treated like a nanny by the kids. They would have me looking after the grandchildren. He thought instead of saving the money, we should use is to enjoy a good life in old age. The children were against this as they felt the people would taunt them, saying they threw their parents out. But my*

husband was adamant and we moved. I was fine with that, though I felt bad that I had to leave my children and grandchildren behind. The tragedy however was that my husband expired within a year – all of a sudden. I however got the courage to get over it. My children told me to come home, but I stuck to my husband's wish; maybe he was right."(Sarita, Resident, Private home)

The above accounts articulate two thoughts, firstly, they illustrate that the attitude towards institutionalised care in Goa is changing and elderly are willing to consider it as an alternative to family living. Secondly and importantly the illustrations point to the abuse of the elderly in families. Besides considering the fact that Sheetal's, Mary's and Alice's decision to enter the home was manipulated by the family, their account gave a different side to this study: the plight of some of the elderly living with their families in Goa. Although the majority of elders may be well-cared for by their families, there are instances of abuse of older people and neglect like those narrated above, which signal the need for a long-term policy for the care of older people in India.

Across all the three homes, the entry was a result of changed circumstances in the lives of residents. Very few residents acted on their own accord to initiate the entry. In general, it was a local parish priest, neighbours, doctors and most importantly families who influenced a resident's decision to move into the care home. The family also had a significant influence on older people's admission into care homes across the three homes. The children were the most influential when it came to deciding the admission. The decision of the children as interpreted from the above accounts was based on the negative attitude to old age, seeing it as dull, less of an opportunity to do new things, more boring and depressing. This raises a question about how far major decisions for older people to relocate are made on casual recommendations from others and sometimes even without their consent.

As evident from this section, the residents described the entry as a new life, but also as a life that they were confined to without much individual choice. Preparation for moving to care homes represented an opportunity to tie up the loose ends of the past, discard unnecessary trappings, and prepare for creating a new home (Young, 1998). Many residents appreciated the fact that they had been able to execute some control over this process and recognised that failing health or physical

ability would have precluded their involvement. For some older people this move to a residential care setting may be viewed positively. The vulnerability which s/he experienced in the family setting may be such as to make the move both more acceptable and manageable. The next section will describe the actual moving – in process which was usually quick and rushed.

5.4. Moving in

As seen from the above sections, for a majority of residents the decision about residential care was usually undertaken by someone else. While research on moving into a care home has focused primarily on characteristics of the move and individual responses to relocation, minimal attention has been focused on the actual preparation and process of moving (Young, 1998). Mercer *et al.,* (1989) in their study of 80 women over the age of 60 identified a uniform process of moving in comprising 7 phases: pre-decision, decision to move, physical and mental preparation, packing and leave-taking, travelling, unpacking and relocating, and the settling-in. Wiersma (2007) spoke of residents' preparation to move in, which included expectations (for when they would be coming into the home as well as what the home would be like), past institutional experiences (if any), and community connections that they had in the home. In my study, where the decision for the majority of the residents was made by someone other than the resident and where residential care only materialised when the intergenerational contract ruptured, did the residents have time to prepare for a move? In this section I aim to describe the experience of moving into residential care from the point of view of those who moved in.

As noted from the discussion above, the move into long term care can be contextualised by the preparation to come into it. A few (8, n=24) among the residents I interviewed had the details as to where they were going; three of them were from the religious home, one from the Government and four others from the private home. The remaining, as Gibbs and Sinclair (1992) put it, appeared to be resigned to or ambivalent about the idea of going into a home or entirely rejected it. From the 8 residents who knew where they were going, only four had explored other homes, and the remaining four chose this setting without evaluating alternatives (on

the basis of recommendations made by family and friends). Financial arrangements, independence and freedom in the chosen home were the main criteria.

The length of the preparation phase also differed; some residents like Arjun had the opportunity to plan several months in advance of the move and to make an informed choice by surveying various homes. Others who had no involvement in the decision to move into the home or its selection were rushed into the home by families with as little as a couple of days or as in the case of Fatima, had no time at all for preparing for this move. Residents who made an informed choice or who were involved in the decision to move into the home reported the greatest satisfaction with the decision and the process of moving.

A majority of the residents who were forced into moving in the home reported negative feelings about the preparation. The most frequent comments included

> *"I didn't expect to come in here….it is not meant for people like me…it is for destitute people…but they (children) forced me into accepting it…I agreed and made myself accept the fact that I was also destitute now." (Carmen, Resident, Government home)*

> *"They always knew I hated the idea of entering a care home….so they did not even tell me…I did not even know I was coming here…" (Fatima, Resident, Religious home)*

> *"My sister informed me that I was supposed to move here in seven days. I told her I needed to pack and all, but she told me that they do not allow many things to be brought in so I needed to just pack two sets of clothes, the home would provide everything else. She also said that she would bring in things if I felt I needed them later. She gave me a polythene bag for my clothes and was rushed here* (*godbodan*)*" (Alice, Resident, Government home)*

The accounts above suggest that there is very little evidence of older people planning a move into a home and yet there are examples of residents who want to shed the risks and responsibilities of living by themselves.

> *"I decided to come here and look forward to it as I thought living alone would be too risky…" (Rekha, Resident, Religious home)*

> *"I lived alone and hence relied on others to help with paying bills, shopping etc. So I decided to move in here…here you*

> *pay your monthly fee and rest assured" (Leena, Resident, Religious home)*

There were a few residents who had familiar people inside the home and this helped them look forward to the move.

> *"I knew Violet; she was from the same village as mine….our families knew each other….I knew she would be there for me when I go in. When I came in she introduced me to people and she was constantly there when I used to feel sad and miss my family. She always looked out for me especially in the beginning, telling me what to do and what not to. Now, she is my best friend here. When we talk about our past we both can relate to it…her being here has helped me." (Mary, Resident, Religious home)*

These connections helped to create an identity for the residents that was before their lives in the care home and helped them to get to know others and to adjust to the home. Thus, there was some recognition of who the residents were prior to admission. This element of continuity was shown to ease the moving in process.

Stigma *(Dagg)* which was attached to care homes was a final but significant factor which influenced the residents' move. Entering a care home challenges strong cultural beliefs about the normal life course for Indian older people and every one I interviewed recalled incidents where they felt reduced in the eyes of others while entering the home. As stigma theory predicts, these older people were marked as departing from the ordinary and natural. By reflecting on the accounts below, one will be able to understand the way in which society in general and residents in particular viewed their entry to a care home in Goa.

> *"I hated the thought of coming in as I was worried about what people would think…..they are talking even now…I did not even say bye to anyone because I knew they would say 'oh she has eight children, yet today she has no one to care for her. Such a shame (loz). They all gave me pitiable looks. It was very upsetting" (Gopi, Resident, Private home)*

> *"You know how people talk about coming in here right, things like 'oh you have no one to care of you, such a shame. Even the staff sometimes say things like 'You must have done something bad that is why you are here'…" (Laxmi, Resident, Government home)*

> *"Who wants to enter a care home? It is for someone who does not have anyone and it is basically a place where you*

> *will die soon and who wants to die in the midst of strangers, not me at least. I hated the thought of coming in but my daughter said this place is different so I said fine…" (Fatima, Resident, Religious home)*
>
> *"People ask unwanted questions when you tell them that you are going into a home. Things like 'Did your children ask you to move out' 'such a shame you have only daughters, if you had sons they would take care of you'. It was I who decided to enter the home not my daughters. These gossipers troubled my daughters too, asking them, why they admitted their father into the home?"(Arjun, Resident, Private home)*

The above accounts illustrated older people's exposure to stigma within personal and public encounters. These discrediting encounters led to the older people attaching shame and distress to their move into the home.

For the residents in this study, the move was thus contextualised by the expectations and anticipation of long-term care: apart from connecting with familiar people it entailed loneliness, desolation, a place for the dying, and the stigma of being in a care home. A number of researchers have identified characteristics of the transition and of the environment that influence adaptation (Mirotznik and Ruskin 1984; Schulz and Brenner 1977). These include controllability and predictability, social structure of the new environment, degree of preparation for the move, and the importance of possessions. This section supported these previous findings. Residents like Arjun who played a central role in the decision making process reported significantly greater feelings of satisfaction with the move and control over the outcome of a transition (Lieberman and Tobin, 1983). The meaning of the move, as an effort to obtain sheltered care, was more readily accommodated and accepted when the participant was involved in identifying the need, deciding to move, and preparing for the move.

5.5. Conclusion

In this chapter, I have illustrated a deeper understanding of the reasons for entry into care homes from the perspective of residents. Residents in all three homes felt led towards the admissions either as a result of decisions made by others or as a result of their perceived dependency (*dusreachea khalla asop)* which they equated with old age. A number of reasons accounted for the entry. In a few cases,

deteriorating health was mentioned as the reason for admission. However, in many cases the older people's concerns about their ability to look after themselves in the future underpinned the move. Some of the residents had no family to look after them and some had family who were either unwilling or unable to support them. Several reasons were cited for the withdrawal of family support. In some cases children had migrated abroad. Others reported that families did not want to care for older persons because of the financial burden of doing so and some others spoke of abuse. The preparation towards this entry for some was rushed and for others was filled with negative expectations and anticipations of entry – loneliness, desolation, a place for the dying (*moron)* and stigma *(dagg)* of being in a care home. In the analysis of illustrations in the two sections of these manifestations I have pointed to an overpowering neglect of older people's choices (*icchas)* and autonomy (*aplo adhikar)* in this decision.

Traditionally, elders have been venerated in Indian society and scholars claim that this continues to remain the dominant theme in how families care for elders today (Brijnath, 2012; Rao, 1993). Though I do not reject this fact, the findings of this chapter have demonstrated that family care is not guaranteed for the entire older population in Goa; indeed, instances of neglect and abuse were often mentioned by the residents as a main reason that led to their entry into a care home. As illustrated in the sections above, the residents spoke of 'emotional problems', 'neglect by the family members', "feeling of insecurity", 'demeaning taunting', 'loss of dignity', 'maltreatment', and 'disrespect' by the family prior to their entry into the home. The assumptions that the extended family always provides a safety net for older people risks perpetuating complacency among health policy makers, social welfare and health care providers. Although families are the principal caregivers for the aged in Goa, it is also clear that this arrangement is not always to the benefit of the older people. The answer to the question, 'who cares for older people in Goa?' is clearly the family. However, the single dominant theme across all residents interviewed has been the concern that respect for older people and the caring traditions of the extended family are changing; elderly abuse in families is increasing rapidly (Soneja, 2001). The single residents – widowed unmarried and separated – can be seen as the worst sufferers of abuse and neglect in Goa. The constant fear they spoke of prior to

their entry in the home was that of being abandoned or neglected. Marginalisation was reflected in feelings of abandonment by the family. With this underplay, the care homes are the only alternative care arrangement that older people in Goa have to turn towards. Because many of them expect to be cared for by their children in their own homes, their admission to a care home represents to them a sense of parental failure and loss of respect. As a result, though the move has been viewed as stigmatised, older people are willing to consider it as a viable option for the present and the future.

A few residents however spoke of their preference in choosing the home. Tobin and Lieberman (1976) contend that the resident-to-be cannot afford to be rejected because the home has been determined to be the best, if not the only, solution available. To handle the rejection and to maintain self-esteem, the resident-to-be usually emphasises that the decision to enter the institution was wholly his or her own. They suggest that for some people this may be a reasonable mechanism for coping with anger and fear. This proposition however presumes that most old people have this fear of rejection which may or may not be true. However a deeper look into the account of residents I interviewed demonstrated a fear of rejection in the near future even to those like Arjun for whom the move was an individual choice. His comments which included phrases like ‘not sure of what my daughters would say in the future’, ‘before it is too late’ and ‘wanted continuity’ spoke about a change in the way his family/society would view him. Violet’s conscious decision was based on her fear of loneliness. Similarly Valerian’s account, “I have only one daughter. I did not want to be a burden on her and asked to leave” and Marcus’s response “My son had got a job in the Gulf. I did not want to be in his way” to my question about their moving into the care home evince a choice in their decision to move, however there are two different strands in the reasons for entering the home. One acknowledges that the old person may be in the way of the family while the second stresses the wish not to be a burden. Thus in both the strands, growing old was seen as a change in the world view of oneself and moving into an care home was seen as escaping from this view.

The above accounts reflect a spectrum of initial reactions to entering the home which included despair, hopelessness, helplessness, abandonment, stigma and

anxiety about the future. The accounts reflect some unique experiences which related to their individual personal identities. The findings reflect older people being caught between the changes in family system on one hand, and the absence of an adequate social security system on the other. Eventually however they had to reconcile themselves to the notion of being a part of a care home and attempt to create a new meaning of the present scenario. The next chapter addresses this transition.

Chapter 6: “Don’t try to fight it”: Perspectives on older people's transition into care homes

6.1. Introduction

> *“All your life you get used to doing things in a similar way and one day you walk into this place and you have to begin doing the same things differently. There is no time to sit and think why; you just have to do it and in a while you get used to it” (Carmen, Resident, Government home)*

Carmen’s account above helps us to understand her entry, transition and adjustment to a care home as one that is characterised by compliance and powerlessness. The new lifestyle she could see herself adjusting to and acquiring can be perceived as controlled and imposed without much time to comprehend the change. This is an emotion repeatedly reported in interviews with residents in this study, which suggests the necessity of a closer look into this transition within the rules of the care home and the adjustment of the resident.

In the previous chapter, I pointed to the role that changing family system plays in older people's move into care homes. In this chapter, I show what happens to the older people on the threshold of residential care, as they begin to construct their lives as residents of a care home – the entry stage. I will be drawing on the perspective of 24 residents, 12 staff, and 4 managers to reflect on the residents’ experiences at entry in the home. In particular, I consider whether – and if so, how – the process of moving into a care home undermines and/or retains the ability of older people to retain a positive sense of identity (*osmitay).*

In gaining an understanding to the above question, I begin with a theoretical discussion about the transition of older people into care homes and the issues that have an impact on this transition. I then go on to explore the changes and conditions that the residents experienced during their transition, by focusing on four themes: experiences at entry, initiation into the home, initial impressions, and initial attempts at adjusting. These themes are examined along the lines of how the interactions, rules, norms, and patterns of behaviour within care homes shape the initial transition experience of older people.

6.2. Transition of older people to care homes

Transition or relocation to a different environment is a life event that challenges older people (Reinardy, 1992). Lee (1999) claims that in comparison to people of other ages, older people are particularly vulnerable to changes in their living conditions because of their increased dependency upon environmental cues. Muhlenkamp *et al.,* (1975) reported that older people ranked changes in living conditions and residence as requiring significantly higher magnitudes of adjustment than younger people do. Thus while there is evidence of the stressful quality of relocation for all people, it has been described as one of the most difficult problems facing older people (Zarit & Whitlatch, 1992). According to Lee (1999) there are four main categories of relocation occurring among older people, classified according to the degree of environmental changes that follow. These include residential, intra-institutional, inter-institutional, and residential-institutional relocations. Among these relocation types, transition to care homes has been found to be the most significant and stressful relocation (Coughlan & Ward, 2007; Reuss, *et al.*, 2005; Young, 1998). However, even though it is one of the most challenging and stressful events, it has been noted that this type of relocation is a common phenomenon in the lives of older peoples, and for many it is against their choice (Armer, 1996; Rosswurm, 1983). As seen in the previous chapter, most of the residents whom I interviewed were not involved in the decision to enter the care home and at the same time did not have time to prepare for this move. In addition, the admission often represented a sense of breakdown of the family system – the primary care-giver for older people. Hence the entry in many cases carried a stigma of being destitute and helpless.

Although varying in circumstances, an entry into a care home may entail the loss of a home and neighbourhood, fewer opportunities for contact with family and friends, feelings of abandonment, as well as uncertainty and stress over facing the future (Chenitz, 1983). Thus in varying degrees it may evoke feelings of abandonment, stress, and uncertainty (Greene and Dunkle 1992; Mikhail 1992; Brooke 1989; Chenitz 1983). This, it is argued, results from older people being confronted with not just a change in physical location of primary living space, but also a change in daily life patterns, social networks and support, and feelings of

loneliness and isolation (Haight *et al.,* 1998; Johnson, 1996; Regnier *et al.,* 1995). However, some residents, on the contrary, have reported reasons such as boredom and loneliness for their entry (Foley *et al.,* 1992; Coughlin *et al.,* 1990). Therefore, for some residents living alone before the admission, positive consequences of the admission might be anticipated. The role of such cognitive preparation through recognizing the advantages of residential care, it has been suggested, facilitates older people's acceptance of such placement (Lee, 1997).

The transition to care homes may threaten the autonomy and integration of older people, domains that are vital to institutionalised residents' well-being (Frank, 2002). Autonomy consists of decisional control and choice in shaping one's life (Rowles *et al.,* 2003; Frank, 2002), whereas integration consists of one's social networks and sense of belonging (Haight *et al.,* 1998; Fiveash, 1997). The degree to which this happens also depends on the institutional restrictiveness of the setting besides those factors mentioned above (Kellet, 1999; Wilson, 1997). Goffman (1961:26) speaks of admission procedures as trimming or programming as they assist the "new arrival…to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations." These admission procedures are the first indication of the care home attempting to gain the resident's compliance.

The deleterious effects of admission to care homes highlighted above necessitate a discussion on the experiences of such admission from the residents' perspectives. In exploring the lived experience of residents relocating to care homes with the use of in-depth interviews, Nay (1995) found that entering a home meant losing everything for these residents who felt devalued as individuals with no future. Arguing that it is of particular importance to identify the residents' initial experiences of the relocation, Iwasiw *et al.* (1996) investigated the experiences of residents newly admitted to a care home. His study indicated the different emotional reactions ranging from a sense of relief and liberation from family obligation to feelings of sadness, anger, and powerlessness.

The last point of discussion, while attempting to draw a theoretical framework for this chapter, relates to how residents dealt with the various emotions which they felt on coming into a care home. Residents in Brooke's (1987) study

stated that they coped with the residential life by conforming to the rules. Kahn (1999:121) described how his informants accepted the care home's control of the daily schedule in terms of 'making the best of it'. Porter and Clinton (1992: 468-472) identified 'getting used to living there', 'going along with what takes place there', 'fitting in through meshing oneself with the circumstances of residential home life', 'obeying', and 'keeping quiet' as the most common strategies employed by residents for dealing with the changes imposed by residential living. Iwasiw *et al.* (1996) also found that residents in their study fitted into the new home by accepting rules and norms. Engaging in personal idiosyncrasies or other familiar, self-focused activities was also used as a mechanism for dealing with admission experiences (Lee *et al.*, 2002; Porter & Clinton 1992). Exercising control in areas such as when to go to bed or whether to participate in the home's activities, engaging in self-care in areas that residents themselves could manage, and stocking up on their favourite food were also identified (Kahn, 1999). Continuing previous relationships with family and close friends was also an area where residents felt that they could still be in control and could maintain their identity as valued people (Iwasiw *et al.* 1996). Reframing the perception that they were 'useless' because they required residential care was another important approach that residents used to deal with the suffering resulting from the various losses upon placement. In order to reframe their perceptions, older residents compared themselves to other residents (Kahn, 1999; Porter & Clinton, 1992; Brooke, 1987).

The above discussions help to provide a theoretical framework to discuss the narratives of the residents in this study. It highlights four important aspects of the relocation of older people into care homes. These include the residents' experiences at entry, the procedures and practices followed in initiating residents into homes, residents' initial impression on entering the home, and the initial adjustment strategies used by residents. These four aspects are the pillars of my chapter which help in understanding how far the process of moving into care homes influences the ability of older people to retain a positive sense of autonomy (*aplo adhikar)* and control (*formai).* The purpose of this chapter thus is twofold – firstly, to help understand how older people in Goa experience the changes associated with their transition to residential care, and secondly, to explore the events that happen during

admission with and around the residents as they enter an alternative care arrangement for the first time.

In Goa, although the population of older people moving into care homes is growing, there is no readily available information on how they experience the changes associated with such a transition. As argued in the previous chapter (see pages 131 - 133), because many older peoples in Goa expect to be cared for by their children in their own homes, their admission to a care home represents for them a sense of parental failure and loss of respect. Given this cultural consideration of Goan older people, admission to residential care will present specific challenges to them. In order to develop a more culturally relevant transition process for older people in Goa, there is a need to understand the experiences of such admissions from their own perspectives.

6.3. Experiences at admission

Since the entry of older people into care homes was often involuntary, it is not surprising that interviews with residents about their admission experience revealed more negative than positive experiences. This section explores these two dimensions under sub-sections dealing with feelings of loss and feelings of relief and security.

6.3.1. Feelings of loss

The admission to the care home was primarily interpreted as a painful end to everything that had been important to the residents. Feelings of loss (*luksonn*) were frequently identified, resulting in residents experiencing insecurity and a devalued sense of self (Lee *et al.*, 2002). The different losses following placement as perceived by residents have been classified as abstract, material and social (Nay 1995). Abstract loss includes loss of role, lifestyle, freedom, autonomy, and privacy (Iwasiw *et al.*, 1996; Nay 1995; Ryden 1984). Material loss is related to loss of home and personal belongings (Nay 1995; Thomasma *et al.*, 1990), and social loss to loss of family, friends, and pets (Iwasiw *et al.*, 1996; Nay 1995; Patterson 1995). Staff members also identify similar losses for newly admitted elders (Starck 1992). These losses occur individually or in combination. The subsections below illustrate the nature of this experience across the three care homes that I studied.

Material loss

Material loss or *Dhon luksonn* was experienced in diverse ways by the residents – loss of house, community surrounding the house, and items in the house. Rajan expressed his loss of place as representing dejection (*unneponn*), unfamiliarity (*Onolkhi*), and a feeling of being uprooted (*humttailo).*

> *"I had to leave my house which I had built with my own sweat and blood …I feel uprooted from a familiar place to an unfamiliar one" (Field Notes, Private home, September, 2011)*

Sunil discussed the loss of place as a loss of the community that came with and around it. For him, the loss of his home as well as other losses were all tied in with his admission to the home.

> *"It makes you feel sad and dejected (dukhi ani unneponn) and a sense of great defeat (har) dawns on you at first. You lose all the relationships you built for years….What is even more depressing is to think of all the lovely times you had with all the people around and know it is never going to come back." (Sunil, Resident, Private home)*

The loss of possessions (*dhon vostu*) was also significant for many residents across the three homes.

> *"I miss my plants. I had a lovely garden; my daughter gave my plants away when she was shifting me here… I would not be able to bring them with me anyway." (Violet, Resident, Religious home)*

> *"I miss my chair and table. I loved to sit at it and paint. It was so comfortable. They do not allow personal furniture in here and I understand their concern. There is no place for us, where will they put our furniture?" (Julian, Resident, Religious home)*

As pointed in the previous chapter (see page 126-127), a majority of the residents interviewed expressed their coming into the home as being rushed and lacking preparation. As a result the older people had little control (*formai)* over what they could take with them. Additionally, the principle of all the three homes to limit the items at entry in numbers and/or size, did not give the older people much choice (*iccha)*. The accounts of Mary, Carmen, and Rajan below help to illustrate the above argument further:

> *"…. I had this small and pretty chest (pett) which I was not allowed to bring with me here; I had it for our first anniversary from my husband. I did not want to give it away, we even had it repaired thrice and it had cost us a lot. I told Sister (Manager) I want to bring it here. She refused. She said I would not need any of that here, they would be providing everything. My brother eventually took it. " (Mary, Resident, Religious home)*

> *"I hated the thought that I could not have my own stuff here, hence I had to give them away. Now for somebody it is only a thing but for me it is about memories (ugdass) associated with them. When you come in, it is not easy but you get used to it particularly when you see everyone around not having anything." (Carmen, Resident, Government home)*

> *"They told me, I cannot crowd the room as I share it with someone else….I had to limit what I absolutely needed…now there are things you do not absolutely need for everyday use, but the feeling that they are there means so much…(Rajan, Resident, Private home)*

The staff also recognised the depth of *luksonn* (loss) that residents experienced, particularly with the loss of place – both through a loss of home and a loss of possessions.

> *"When you think about leaving your whole home and all your furnishings and coming to one room and you're allowed to bring what, two things? I think it's pretty hard on most of them." (Lata, Staff, Religious home)*

> *"They have to choose a few limited things to bring along, mostly it is two items. I mean, how they choose to bring them versus the other things, I am sure it is difficult for them." (Savita, Staff, Government home)*

> *"It is sometimes their families who choose what they would think important to bring along and sometimes we suggest some other things. So it is all they have, not exactly what they would actually want." (Gabriel, Staff, Government home)*

> *"I am sure all the things we have in our homes have a story (kanni), so it is difficult to choose which story you choose to remember. But they do it and when I go on my rounds, I ask people about their stuff. There is a story behind each one and that is their identity (osmitay), which basically means when they leave things behind or give them away, they give a part of their identity (osmitay) away." (Suraj, Staff, Private home)*

These accounts indicate that the perception of *luksonn* (loss) was related not so much to the *dhon* (material objects) themselves, but rather to what the *dhon* (material objects) symbolised and to the *ugdass* (memories) they evoked. These material possessions provide a sense of continuity and validation of the self for older people (Cram and Paton, 1993). This validation is linked to feeling of security *(suroksha),* control (*formai),* and identity (*osmitay*). Thus a loss of home and personal possessions evokes a loss of associated memories that lead to the resultant negative feelings.

Social Loss

Loss of relationships (*nateachem luksonn*) was very significant for residents in all the three homes. The rupturing of ties with children and grandchildren was mentioned as a significant loss by some residents:

> *"I have waited all my life to retire and then play with my grandchildren, but my admission here was an end to that dream…" (Violet, Resident, Religious home)*

> *"My husband died around 25 years ago, at that time my youngest (of 8 kids) was five years. One of them (youngest) is here but he is into politics and not married. He feels concerned about me being at home alone. Hence four years back they all came home for Ganesh Chathurthi (Hindu festival); it was a lovely function as all my children and grandchildren were here. We had a family meeting, all the children were deciding about my future. I told them I am fine at home, but they said they were worried about me. I told them I want to be around with my grandchildren, and they said they will bring them to the care home. I gave in; I did not want to argue more. I knew they would never bring them. Now I am here with people of my age who moan and groan all the time. I hardly see my children or grandchildren; my son comes once in a while and gives me lectures about how I should moan less and pray more." (Gopi, Resident, Private home)*

Residents also spoke of loss of friends many of whom they grew up with and were of their own age group. They spoke with fondness of the friends who they had lost due to death and friends who they were moved away from when they came to the care home.

> *"I miss the company of friends (Isht) I had. We used to get around near the tinto (village square) and chat (Khobreo) about various thing – political, social, family, anything basically. I miss all of them, they are too old to come here to see me. It was very difficult for me to leave them when I was coming here. There are friends here too but I knew it would never be the same. Old friends are gone and no new friends to take their place." (Lawry, Resident, Private home)*

Julian's relationship with his wife, Angela, had changed significantly over the years because of their health changes and her dementia. While he hadn't lost her physically, he had lost the relationship that once existed between them. However, after entering the Religious home another loss that Julian experienced was the loss of being together with Angela. Allocation of rooms according to sex did not allow them to live together. The separation, particularly in the beginning, was very difficult for both of them, since they had never lived apart for long periods of time during their married life. This was coupled with Angela's dementia.

Loss of pets was also reported as a major factor of residents' unhappiness at entry

> *"I had to give my dog away. They do not allow pets in here and nobody of my friends or family could look after him. He would always listen to me, poor fellow. Some stray ones come along and I feed them but they are here only for the food. At the same time other residnets claim them too. I cannot keep them for myself" (Lawry, Resident, Private home)*

All the above accounts represented a variety of relational losses that residents experienced. These losses reflected a significant shift from the previous roles that residents performed and relationships that they nurtured. This lack of continuation facilitated fear and insecurity among the residents about the care home and life within it – thus creating a negative experience at entry.

Abstract loss

The institutional *formai* (control) in activities of daily living and the demands of group living were identified as contributors to *bhovamanachem luksonn* (abstract loss). This included loss of *mann* (dignity) and *sammann* (respect) in the case of the residents, as identified in the illustrations below.

> *"I knew I would not be able to get out of here. I love evening walks and things like that but they think we would run away so they said they will not allow them. Now tell me, if we would want to run away why would we come here in the first place? And if we want to run away, it is because we are not happy here, so why force us to stay? If we want to go to see a friend or something we have to ask permission in advance, at least a month, and then wait and see if it will be granted." (Lactacio, Resident, Government home)*

> *"My entry in the home was marked by the end of my reign over myself…all decisions concerning my body and my lifestyle were to be taken by the care home. I mean, who likes that? (Felix, Resident, Religious home)*

> *"She (Manager) told me, if I need to stay here I would have to come to the dining area five times a day….I mean, ask me once….(Rajan, Resident, Private home)*

Experiences before admission, such as limited choice (*iccha)* in respect to the entry decision as discussed in the previous chapter (see page 126-127) and feelings of abandonment by the family further reinforce the negative feelings. These negative feelings are further intensified by the constraints encountered after admission. A prominent, uncomfortable feeling was the obvious disruption of the residents' already established daily routine and social relationships. They gave up a great deal on the daily life schedules they had developed before. They expressed this in terms of loss of rights (*hok)*, respect (sam*mann),* and autonomy (*aplo adhikar).* Unfamiliarity with both the new external and internal environment of the home was discussed in the context of feelings of inconvenience. The new environment, together with ill room-mates, resulted in residents feeling very frightened and uneasy with the transition. *'Seeing how those ill residents suffer'*, as one resident remarked, has added to his worry about his failing health upon entry. Self-presentation was seen as very important across all the three homes and an overwhelming control over the residents' dressing styles, table manners, and etiquettes was manifested. The aim was to maintain a high esteem of the home in the eyes of any outsider who visited the home. This however was seen as a negative experience at entry for two reasons; firstly, the arbitrary manner in which the change in self-presentation was demanded and secondly, it was a change in something which the residents had lived with all

their lives and a change that was seen as a challenge to a resident's *osmitay (*identity).

6.3.2. Sense of relief and security

I have so far highlighted the negative experiences associated with admission into care homes. However, it is important to note that some residents I interviewed were able to describe their experiences in a positive manner. Most notable is a sense of *visov or suseog* (relief or consolation) and *suroksha or rakhonn* (security and protection). It was a common theme in the accounts illustrated below.

> *"When I came in, all that mattered to me was a roof over my head and two meals a day. I needed only 'rakhonn' and 'suroksha' and this place provided that." (Laxmi, Resident, Government home)*

> *"The 'visov' feeling got me here and kept me going here. The fact that I would never be lonely and if I fall sick somebody would attend to me." (Sheetal, Resident, Private home)*

> *"I knew I was getting physically weak and would not be able to take care of myself at home. Once I came here, everything was done for me and I felt 'suseog'. I did not have to be responsible for anything, so I had no burden." (Violet, Resident, Religious home)*

The above accounts indicate that the residents appreciated the physical comfort and security the home had to offer. The predominant feeling was a sense of *visov* (relief) at not being alone; relief from worry about managing a household; and at *suroksha and rakhonn* (security and protection). Residents who made a decision to enter the home, or were living alone before the admission, or those who were made destitute by their families, specifically expressed that they were feeling very comfortable with nothing to worry about any more. In recalling their loneliness before the admission and their worries regarding having a roof and having meals served the residents described how they enjoyed being taken care of by others and how they liked the food and the companionship in the home.

6.4. Initiation into the care home: Rules and procedures

In this section I will discuss the admission rules (*nem*) and procedures (*prokriya*) employed by the staff and management in initiating new residents into the

homes. Management and staff across all the three homes employed certain admission rules (*nem*) and procedures (*prokriya)* while initiating residents. These included physical examination, bathing, haircutting, giving instructions as to rules and routines of the home, allocating beds, rooms and seats, undressing, dressing into institutional clothing, searching and unpacking, weighing, and assigning places for storage. The accounts below illustrate these *prokriya* (procedures):

During one of my field visits, I encountered an entry of a new resident into the Government home.

> *"Gaonkar was brought in by one of the religious priests. Gaonkar was asked to visit the nursing room where he was physically examined by the nurse on duty and questioned by the manager while the assistant manager filled forms. Here after, he was sent to a nearby health centre with all the papers, along with one of the junior staff, to have all the papers certified by the doctor. At this point all the other residents were seen gathering into groups along the corridors as he passed and having hypothetical discussions (Khobreo) about him – for example, 'do you think he is sick', 'he looks quite proud, I do not think I will be friends with him'. At the health centre, Gaonkar was checked once again and asked numerous questions about his medical condition. Following this, his papers were certified and he was sent back, given a bath and changed in a different set of clothes, and shown his bed…" (Field notes, Government home, August, 2011)*

Interviews with Management and staff members help to explain the *nem* (rules) at admission better:

> *"When they come in, first we get them medically examined. We then ask the family a series of questions regarding their health. The staff then takes the resident for a bath, dress them in our set of clothes…They get everything here from there on: food, care, and clothes… " (Isabel, Manager, Government home)*

> *"When they come in and after the medical examination, we give them a bath as many of them are dirty and change them into our clothes. Now we give them any clothes we have, in the past we had green uniforms for them so that they could be easily recognised. Now the Government does not have much money so we cannot stitch uniforms anymore." (Savita, Staff, Government home).*

> *"When a resident comes in, we have a certain procedure (prokriya). We ask them a series of questions about their medical history and things like that. Most of them are not sure about why we're doing these medicals, or why we're asking all these questions. So they show reluctance in answering. Hence, we involve the family in helping us fill the forms. (Karuna, Manager, Private home)*

The above observation and accounts point to the importance which rules (*nem*) and procedures (*prokriya*) surrounding physical assessment and cleanliness had during entry. The practices (*sovoi*) operated as a form of initiation of the resident into the care home. Other rules (*nem),* procedures (*prokriya*) and practices (*sovoi)* were also present in the care homes that could be characterised as leaving off and taking on – where leaving off entailed a dispossession (of previous roles, property, and the like) and taking on meant the replacement made by the care home (marked clothes, allocated spaces, uniform treatment, and communal storage space) (Goffman, 1961).

> *"See this is a Government home, you get all your basic needs met – food, clothing, and shelter. Hence on entry we make sure that they (the residents) do not bring in their own clothes and personal items, maybe a couple of night clothes and one formal pair of the same if they have any. We provide everything else. Why do they need it? For example that lady Laxmi had no food to eat when she came in, but she came in with around ten sarees (Indian dress) and ornaments. We sent them all back; there is no fashion parade happening here. They have to be trained to let go, too much greed of worldly things at this age is very bad…" (Rakesh, Assistant Manager, Government home)*

> *"When they come in, sometimes their hair is not washed for days and some of them even have lice….so we instantly bathe them and cut their hair..." (Kareena, Staff, Government home)*

> *"We don't want their personal possessions… the more they have the more they clutter the place…." (Lucy, Staff, Religious home)*

> *"We do not mind them getting their personal items. However, we restrict it as the resident will be sharing the room with another older people. To avoid problems between them, we try to limit the personal items to what fits in the room" (Karuna, Manager, Private home)*

> *"When they come in, we have a chat with them and the family and then we show them their rooms….We help them unpack and put their things in place…if we leave it to them, they clutter the place…we also show them the bathroom and the dining area…from then on the other residents and staff guide them" (Jeanette, Manager, Religious home)*

> *"Besides asking the residents for the physical fitness certificate at admission, we also emphasise the need for walking to the dining area five times a day" (Karuna, Manager, Private home)*

The above accounts from management and staff members point to the entry of residents into care homes as guided by controlling rules and practices. These included restricting personal belongings at entry, unpacking and scrutinising personal belongings of the residents by the staff, random allocation of beds and rooms, and giving oral instructions of the rules and retunes of the home. It was often accompanied by other actions; hair was often cropped short and toenails cut. Personal clothing was replaced by institutional ones. Staff controlled all these rules (*nem*), procedures *(prokriya)* and practices (s*ovoi*) at their discretion. All these rules and practices prevent the residents from presenting his/her usual image to others. They constrain the resident's autonomy and enforce institutional decisions on the residents. It represents more than a desire to impose personal cleanliness and way of living – it represents a change to an entirely new style of life (Townsend, 1962:46).

6.5. Initial impressions

The first few days or weeks is the phase when the impact of the transition to an institution is felt the most. Other studies have described the most severe stress of institutionalisation occurring just after entering the home (Tobin and Lieberman, 1976). As expressed by the residents in my research, this can mean simple issues like '*parki suvater niddunk' (*sleeping in a foreign place), '*dusreacho riti sossunk'* (tolerating the ways of the other individuals), or complex issues like *'hea novea vatavaraneocheo noveo riti and tancheo bereo ani vait kobuli xikonk' (l*earning the positive and negative sanctions of a new environment). These initial reactions help us in understanding the residents' reactions to the various rules (*nem)* and procedures (*prokriya)* described by staff above.

Evidence on how an individual sees himself or herself and his or her activities in the initial days in all the three settings revealed mixed experiences. Many residents were pressed with the need to redefine themselves; as a new resident, s/he was seen as a low status person. On the other hand for some residents, the actual entering and living in the institution does not seem to be disruptive to their identity (*osmitay*). Some residents found ways to interact with peers and the staff that allowed them to reinforce their opinions of themselves. Accounts from the residents below aim to demonstrate these two perspectives. The accounts are divided into two sections: impressions about initial interactions, and impressions on initiation to rules and regulations.

6.5.1. Impressions about initial interactions

Fatima, resident in the Religious home spoke about her initial experience by saying

> *"I really did not like it here. All new faces, new place, sleeping in the company of others, having to share table space with others. Oh, I did not like it at all, but this is where I was to live my life from then on. There was no escape."*

Her initial impression was further tainted by the overwhelming nature of staff involvement:

> *"….I started unpacking….all residents and staff around me to see what I had…the staff stepped in, unpacked my stuff and put it in place….I was left watching…I hated that…." (Fatima, Resident, Religious home)*

Residents also spoke about their initial difficulties in attempting to build new relationships within the home after a loss of their old ones:

> *"When I arrived I was shown my bed; there were around 16 other residents in that room. None of them greeted me; they did not know me so you cannot blame them. But they continued staring at me from different angles. This continued for 2 days, so it began to get depressing having no one to talk to. What common interest did we have?...so cannot really blame them…I missed friends back home but the good thing was, I had no work to do here like at home.…(Milena, Resident, Government home)*

> *"I am happy that I have so many people to talk to as I used to be very lonely at home" (Carmen, Resident, Government home)*

Rajan spoke about the arbitrary decisions (*khushe parmane formai*) regarding the rooms and roommates by the management.

> *"In my first week I was asked to move twice between two cottages and three roommates…I told the manager I wanted to stay in the first as that resident and me got along well…and there was a place as well but they did not allow, they said they reserved it for someone else….I was kept with this person who is forever ill and keeps crying of pains…life gets so depressing…I hate the management; they are very matlabi (people who looks for benefit)" (Rajan, Resident, Private home)*

Julian from the Religious home was afraid of the stigma (*dagg*) which is attached to a care home and this feeling undermined his initial experiences:

> *"I did not want to meet anyone or see any visitors. I preferred to be in bed. I wanted to avoid any form of contact. Everyone used to gossip (gozal) and then ask me: why have you come here, is there no one to look after you? You do not have any money? Different questions were thrown in my face as if I have committed a big sin. I felt stigmatised (dag laglo) I could not have meals in the room, I had to sit in a big common dining area near people who I did not like and I had to come for meals at a particular time like a robot. I did not like that" (Julian, Resident, Religious home)*

Marcus and Felix were also affected by the lack of interpersonal relationships in the Religious home

> *"Sister (Manager) showed me my room…which I shared with two other people….when I entered they never spoke to me…one always chanted 'I want to go out of this place' and the other just stared in space….just then the staff came in to hand me bedsheets….she did not smile or greet me…I later realised that she does not speak English or Konkani and did not want to learn….When I went to the living room many residents were seated there but nobody talked to each other…I made an attempt at making conversation but there was only a yes or no…now you see me; I am the same…the home just trains you automatically.." (Marcus, Resident, Religious home)*

> *"….everyone kept staring in space…no one really wanted to talk…" (Felix, Resident, Religious home)*

Alice from the Government home commented on her initial feeling by saying:

> *"I arrived at lunch time. The staff here gave me water to drink…I was dirty when I came in, they (staff) stripped me in the dormitory and escorted me to the bathroom. I felt shy and embarrassed (loz zali) as all the others were watching, but I just kept silent and let them do their job…..they gave me food to eat; I had to eat it on the bed. It was weird that I had to sit at my bed and eat; nevertheless I thanked God for the food and ate. But none of the residents greeted me; they did not know me so you cannot blame them. But they continued staring at me from different angles. Eventually I made friends with one of the residents who was next to me because I was getting depressed. Another resident also came along to talk to me, so slowly I made friends with others."(Alice, Resident, Government home)*

Sunil from the Private home had a different experience on entering the home.

> *"When I came in, I was very excited. In the first two months everything was fine, I noticed that the behaviours of people were changing. I was wondering what had happened, people suddenly started talking less etc. I was wondering whether it is something about me, did I hurt them and things like that. But after two months I realised that people here are crabs[25], I was getting involved with the management and helping out, so they could not tolerate that. They did not want me to take up any job. This affects natural drive. So the alternative is think and think and become stressed. But I confided in another resident who I can call my only friend here. We eat at the same table; he also lives next to my room." (Sunil, Resident, Private home)*

Sarita spoke about how her entry into the home was a positive experience.

> *"What I remember most about my first day was that I had loads of time to watch television and read…I had got off, no more tedious housework" (Sarita, Resident, Private home)*

Violet had a similar experience where she was most happy about having a friendly roommate:

> *"I had a nice roommate waiting to greet me….she knew Portuguese as well which was very good…I was very happy*

[25] This expression refers to the metaphor of crab mentality best described by the phrase, 'if I cannot have it, neither can you'. In Goa this metaphor is used colloquially to refer to anyone trying to better his circumstances but is prevented to do the same by others who do not want them to be successful.

that I would not be on my own….my prayer was also my strength." (Violet, Resident, Religious home)

The initial impressions about the initial relationships illustrated above provide a negative impression of the support received by the residents from the care homes to build new relationships within it. A focus on building relationships within the care homes is a step towards good practice which will assist older people to smooth their adjustment within the care home.

6.5.2. Impressions on initiation to rules and regulations *(nem ani kaide*)

There were some residents, even though in a minority, who valued the existence of rules and regulations in the maintenance of harmony and order in the home which they considered more important than the individual sense of control (*formai)* and autonomy (*aplo adhikar).* Hence they spoke of the importance of being cooperative and not being seen as 'troublesome'. Two residents refereed to the Goan proverb *"Ganv toho bhes"* (when in Rome, do as the Romans do). In fact, learning about the *'nove sovoi'* (new practices), as one resident called it, was seen as a legitimate and important agenda for them. Moreover, it is worth reiterating that for some of these residents admission to the care home opened the door to a secure living environment where their basic needs were guaranteed. These residents considered themselves lucky to have been 'given' a place in the home. They considered that they should therefore be thankful and observe the rules and regulations as much as possible. In analysing these positive responses to rules and regulations, one important aspect of Indian society comes to the fore. Indian society attributes high importance to discipline in socialisation (Rao et al, 2003). An example of this is reflected in the fact that children are taught to be obedient and follow clear lines of authority which may involve a continual display of obedience throughout their life (Rao et al, 2003; Lee, 2001; Hsu 1985). Hence, some residents accepted and obeyed these rules and regulations without any questions. Indeed, they were rather frightened of breaking these rules because of the fear of repercussions and embarrassment they would face as will be discussed in Chapter 8 (see pages 209-210). Though rules and regulations were seen as needed, the inflexibility of these rules coupled with the idea that rules were to be given by the elders to the younger and not vice versa caused inconvenience to the residents:

> *"The rules and regulations were upsetting. I like to sleep when I feel sleepy. Their times to bring morning and evening tea is when I like to sleep. They get angry then, so I try to obey." (Valerian, Resident, Government home)*

> *"The first thing I was told was that I would not be able to go out….I was fine with that but what appalled me was being locked in the dormitory…I remember banging the dormitory doors….it is fine in the nights but why in the afternoons" (Lactacio, Resident, Government home)*

Rajan however was upset about walking five times to the dinning cottage to have meals.

> *"I felt I had entered a hostel and was going into a mess for my meals. It was not like home." (Rajan, Resident, Private home)*

> *"I found it strange that I had to wait in a queue to get my food…anyway, at least I got food so I do not want to grumble" (Milena, Resident, Government home)*

> *"I had to get myself trained to the idea that my world was on my bed and my dormitory…..…" (Carmen, Resident, Government home)*

Alice added:

> *"What I hated most about coming in was that, they made me cut my hair after a week's time in the home….I hated that" (Alice, Resident, Government home)*

Laxmi, Valerian, Carmen had similar concerns:

> *"When I came in, I noticed the staff barging into dormitories and giving orders. They were very loud and demanding so you do not have a choice but do as they say" (Laxmi, Resident, Government home)*

> *"I arrived in the evening and immediately I was given a bath and asked by the staff to go to bed and lights were switched off….imagine sleeping with around 20 strangers around you….some moaning loudly…It was very scary in the night…I cried all night…" (Valerian, Resident, Government home)*

> *"…I was shown to the dormitory and told I had a bed and a small steel drawer for me which had no lock….I had to keep my clothes in a compartment in a wall shared by others (see figure 6.1)" (Carmen, Resident, Government home)*

Figure 6.1: Storage space in the Government home

Reggie added to this by narrating his experience of the first morning:

> *"When I arrived on the first day sister (the manager) told me 'to feel at home'…the next morning…I woke up and was strolling the house with my pyjamas on……I was in the dining area and everyone was around…she told me I am not supposed to be in my pyjamas as this is not my home, I needed get changed into a shirt and long trousers….later on at the breakfast table I used my hand and again she came along and insisted I use a fork and knife and said she would teach me if I did not know how to use them….I was not only embarrassed but also realised that this is not my home and I needed to behave in a certain manner." (Reggie, Resident, Religious home)*

Milena spoke about the demand to change her physical appearance:

> *"….When I first entered around 15 years back….I still remember I had to change and get into the green uniform….. it made you feel like a patient in a hospital" (Milena, Resident, Government home)*

The above accounts reflect a spectrum of initial reactions to entering the home which included despair, hopelessness, helplessness, abandonment, fear of stigma, anxiety about the future, and unhappiness about the self and others. The accounts reflect some unique experiences which related to their individual personal identities. However they had to reconcile themselves eventually to the notion of being a part of the home, and to attempt to create a new meaning of the present scenario. The next section will endeavour to address the ways in which residents attempted to reconcile the above impressions.

6.6. Dealing with admission experiences

How did residents understand and deal with the range of negative and positive adjustment experiences, in order to continue living their new lives in the care home? Accounts by residents expressed the different ways in which they attempted to reconcile their different initial encounters in the care home. I have discussed these under three headings: passive acceptance, making the best of the available options, and comparing.

6.6.1. Passive acceptance

Passive acceptance (*vogiponan manun gevop)* was the major approach used to deal with the different constraints of residential living, such as the regimentation of everyday life and the unpleasant nature of group living. Residents spoke of conforming to the norms and routines of residential life.

> *"It's a hard routine to get into, but you eventually come to get more settled into a routine….you have to train yourself to do it and that is the best way" (Lactacio, Resident, Government home)*

> *"You fall into a routine….which is a good thing. You can't fight, so go along….I kept getting embarrassed if I did not follow the rules…so following the rules quietly was the best way out." (Reggie, Resident, Religious home)*

Raja stated that he had become accustomed to the life that is afforded to residents in the Government home, although it was a difficult transition for him at first.

> *"Today if a new resident comes I will say, 'at first I was like you. I was horrified when I entered. All my life I had my privacy as I have been single. All of a sudden you have to give it up. They (staff) come in when they like, even if you are changing. If you are a bit slow, they come in and give you a hand even if you do not want it, and you're happy about it. And you joke about it, and ultimately you get used to it. Like I said, if you go with the flow, you get used to it. Don't try to fight it.' (Raja, Resident, Government home)*

Felix spoke about his frustration with the rules and regulations (*nem and kaide*) of the home:

> *"I was told everything on the first day and they expected me to remember all these nem ani kaide and if you do not, you are taunted (Tanne martat)…I just began following other*

residents and that way I learnt" (Felix, Resident, Religious home)

Lawry said that he was aware from the beginning that this would be a different place from his own home:

> *"… thus on the first day I maintained limited contact and did what I saw everyone doing…eventually I learnt the ropes" (Lawry, Resident, Private home)*

Passively accepting (*vogi manun gevun)* the situation was closely related to the residents' perceived loss of control (*formai),* especially *formai* over their daily lives. However, passive acceptance was different from real acceptance. Although the residents conformed and got used to the norms and routines, they did not specifically embrace them. They conformed because they did not have any choice. Moreover, as will be seen in Chapter 8 (see pages 201-206), there are subtle ways in which the same residents did not embrace the rules and regulations entirely.

6.6.2. Making the best of available options

Closely connected with the use of passive acceptance was the approach of making the best of available choices. For Leena, the home was a refuge she needed and was a place where she did not have to worry about the next day. She used this approach to help to soothe the admission process.

> *"…I would not have to worry about what would happen the next day….mostly about my health. I knew that there would be someone to check on me…This kept me going and gave me visov (relief) and suseog (consolation)" (Leena, Resident, Government home)*

For Felix, it was the mobile phone he had which gave him the opportunity to continue previous relationships with relatives and close friends. This was for him an area over which he thought he could exercise his control (*formai).*

> *"…It was because of the phone I survived this place…there was no one to talk to, only orders….I used to talk to my friends and sister when I was in the room and this helped me." (Felix, Resident, Religious home)*

Spirituality *(bhoktiponn)* was seen by many residents as a coping mechanism. Laxmi revealed that her spirituality *(bhoktiponn)* helped her to gain control (*formai).* According to her, the prayers she recited daily helped her cope.

> *"I pray to God to give me some strength and that is the only reason I survive here … (Laxmi, Resident, Government home)*

Similarly Madhuri from the Private home was always seen with holy beads, which she used to recite her prayers.

> *"I pray the whole day. I pray for the staff or other residents and for the world. This keeps me occupied, gives me a purpose and keeps me happy..."*

It is evident from the accounts above that the residents focused on those aspects of life in the home that they could still control (*formai)*. This gave them a feeling of maintaining their autonomy in some aspects alongside helping as a coping mechanism.

6.6.3. Comparing

As discussed in the theoretical framework at the beginning of the chapter, new residents attempted comparing (*sar karun*) themselves with other residents. The motive was to enable the new residents to think of themselves as different from the others. Different areas for comparison were identified: health in terms of physical and cognitive functioning was most frequently compared; social status, family, and financial situations were also favourite comparisons. The accounts below are manifestations of comparisons that take place across the care homes – which in turn allow a resident to cope with the depersonalisation (*monxak kirkoll korop*) in the care home:

> *"Look at Gopi. She has eight children yet she has landed here. At least I do not have children who have deserted me" (Sunil, Resident, Private home)*

> *"On my first night all these men were groaning and moaning; I could not sleep and was upset. But I also felt sad for them because of their poor health and who can they say it to? Nobody" (Lactacio, Resident, Government home)*

> *"These are an ignorant lot….I am educated and know my rights and responsibilities. The staff also realised that eventually and stopped bossing me around…" (Carmen, Resident, Government home)*

> *"I did not want to interfere with all the ladies in here…they only gossip or spy for the nuns. I kept myself aloof because I*

> *do not like all this nonsense." (Felix, Resident, Religious home)*

> *"Money is very important…I get my pension every month. The others have to rely on their families for money. That makes it more difficult for them" (Arjun Resident, Private home)*

Madhuri from the Private home had a different explanation for her initial adjustment to the home:

> *"Entering this place for me was like going on Sanyas (renunciation). I had fulfilled all my other roles and now it was for renunciation. This place with all its rules and regulation provides a perfect place for Sanyas…you see all the others talking and wasting their time…they do not know how to overcome these worldly temptations…I prefer solitude and it is very rewarding"*

Such comparisons enabled the residents to put their situations into perspective and helped them to cope with the depersonalisation (*monxak kirkoll korop)* of the home's regimen (Kahn, 1999). Even a certain kind of denial of reality, in this case not giving thought to residential care, was found to be functional in the short term (Greene & Dunkle, 1992).

6.7. Conclusion

In this chapter I examined the initial experiences of the residents when they were admitted into care homes. It is evident that a number of issues suggested in the literature as barriers to adjustment to residential care, such as living with rules (*nem*), stigma (*dagg*), and losses (*luksonn*) (Iwasiw *et al.,* 1996; Thomasma *et al.,* 1990; Brooke 1989) were regarded as important by the residents in my study. How can these older people be helped to go through the new experience with dignity (m*ann*)? Control (*formai)* over activities of daily living, for example, create anxiety and stress and lead to a devalued sense of identity (*osmitay)* (Nay, 1995; Thomasma *et al.,* 1990).

Entry into care homes incorporated various responses from the residents. Residents interviewed reported negative experiences at entry: issues related to privacy, staff behaviour, regimentation of the home, and problems in developing new relationships. Some also spoke of the positive benefits of the homes including benefitting from *visov* (relief) and *rakhon* (security): providing their basic necessities

i.e. *jevunk ani ravpak melta* (get to eat and stay), ‘having someone to talk to unlike in their own homes’, and ‘getting rid of their household chores which they were tired of’.

Residents’ initial experiences with the staff – who were overpowering their personal decisions leaving the residents with feelings of losing control (*formai)* over their lives (including cutting of hair and their physical presentation) – made them passive to the rules and regulations of the home. The residents expressed having little time for the admissions process to sink in, let alone the rules and regulations of the home, which made them mechanical in doing what was asked of them. They describe coming to the home with an emotional baggage of loss and rejection; instead of helping them to cope with these losses and rejection, an emphasis was put by management on the successful running of the care home. Some residents also found that the rules and regulations undermined their previous way of living and introduced them to a whole new one; this included issues like their meal and bed times, physical appearance in the home, and table manners. However, the residents also expressed how they ‘just went with the flow’ and never revealed these uncomfortable issues to the staff or management as they considered themselves too ‘new’ to comment on these well-established regulations. For example, Marcus from the Religious home said that he ‘dared not’ criticise the home and be seen as `troublesome'. Iwasiw *et al.*, (1996) question whether this reluctance is indicative of feelings of vulnerability, of congruence with an attitude of tolerance, or both.

Communal relationships with other people as a result of the dormitory setting or the two and four bedroom set up were valued particularly by residents who felt lonely in their own homes. However, many residents found being in the midst of strangers very intimidating. The difficulty of being in a strange place particularly at night time, loneliness, and meeting strangers (their fellow residents) were most apparent then. The sleeping spaces were seen as constantly encroached places by peers and staff. The claim of the staff over these areas as part of an institution with structures, rules, and routines that needs to be observed was apparent, as opposed to the resident’s sense of it as a private/personal space. In this sense, the residents adjusted and were placed within the structures of the institution from the first day.

They attempted to redefine notions of privacy to fit within the context of the care home. Thus the residents evoked feelings of losing control over their own decisions.

The resident at entry was seen as facing a number of losses and thereby acquiring a dependent identity, being increasingly defined by the structures, practices, and regulations in place in the care home. This evidence reflects the need for a further insight into the daily practices and processes and their impact on the residents' lives as they come to terms with institutional living. This will be the focus of the next chapter.

Chapter 7: "I am a machine here": Control and dependency

7.1. Introduction

> *"They tell me to do this and then they tell me to do that. I do not want to do either of it but I have to in the end."(Mary, Resident, Religious home)*

Mary's response was perhaps a reaction to the complexities of her life in the care home – the controls, practices and procedures, the staff-resident relationships, and the dependent identity which she could see herself acquiring, an identity which was created after her many losses experienced prior to and at the time of entering the home. My aim in this chapter is to make sense of the residents' lives after entering a care home in the context of Goa – telling their stories and conveying the uniqueness and ordinariness of their everyday experiences. Focussing on the lives of the residents within the three homes, I will unravel the day-to-day implications of balancing dependence and independence for older people in residential settings, and illuminate how institutional power and staff practices constrain their lives. This study, then, not only attempts to understand residents' experiences in care homes, but also critically explores how power (*xokti)* and staff practices *(kamdaracheo chali)* within them define and limit residents' autonomy (*aplo adhikar).*

I begin with a theoretical discussion of institutional care and dependency of residents, followed by an analysis of three forms of control manifested in the care homes which facilitate dependency: group living philosophy, rigidity of rules and regulations, and staff and management practices. Each section has a brief theoretical discussion and then analyses relevant data from my fieldwork. Field notes from participant observation across the three homes and interviews with 24 residents, 12 staff and 4 managers within them are used as data.

7.2. Institutional care and dependency

Booth (1985:418) describes dependency as "a feature of the human condition in which the only real freedom is the capacity to choose on whom or what to depend". However, other scholars have argued for different descriptions of

dependency. For instance, Kalish (1969:83) has pointed to its different meanings: “a relationship, a condition, a personality characteristic, or a particular example of behaviour.” Similarly, Walker (1982) has pointed to the different senses in which the term has been used: life-cycle dependency, physical and mental dependency, political dependency, economic and financial dependency, and structural dependency. Before discussing the dependency that exists within institutions, I set out my understanding of dependency in relation to the residents of care home whose experiences I illustrate. I use the concept of dependency to describe the different aspects of the residents’ relationships with the staff, their work, and the institutional rules and procedures; all of which shape their behaviours and perceptions about their own lives.

Induced dependency theory implies that institutions, because of their restricted and controlled nature, produce passive and dependent residents (Booth, 1985). Accordingly, Goffman (1961) argues that regimentation in everyday life in institutions creates power structures that direct and control day to day workings in them. These power structures pervade every aspect of an individual’s life – work, activities, and relationships – through the rules and regulations that are in place in them. The manifestations of these power structures are witnessed in the power relationships and social distance that exist between the staff and residents, which he refers to as binary management (Goffman, 1961). The implication is that these power structures lead to a ‘stripping’ of the resident's self-identity, termed as depersonalisation by King and Raynes (1968). Thus in the theory of induced dependency, on the one hand, the institution takes care of all the needs of its residents and, on the other, it produces regimentation. In the outside world regimentation is limited to work space; in the institution it reaches into all spheres of life, thus creating dependent individuals.

Care homes have acquired and carried very negative perceptions and connotations (Groger, 1995). Many researchers have attempted to identify and theorise the characteristics that contribute to creating these negative perceptions. The explanations have pointed to the powerful all-encompassing components that create dependency, helplessness, apathy, and disorientation in the mind of its residents. Induced dependency theory has been used by many researchers to explain this

phenomenon in care homes (Wiersma, 2007; Mali, 2008). Mali (2008:433) defines an institution like care home as an

> "organised system of written and unwritten rules which define life in the institution subject to a spatial connectedness (a shared dining room, common rooms for afternoon rest, joint recreation) and a minimum level of privacy and independence".

Hazan (2002:341) describes care homes on similar lines as cultural enclaves and cosmological voids:

> "Care homes are cosmological niches where subversive agents of non-modernity can be contained until they are removed and processed to become controllable 'others'".

Thus both Mali and Hazan perceive the induced structures in care homes as very controlling and restrictive. The outcome is what they call the creation of 'controlled and passive residents'.

Care homes have also been analysed through this lens of induced dependency by several other researchers, many of them using an ethnographic approach (Wilkin and Hughes, 1987, Booth, 1985; Willcocks *et al.*, 1987; Diamond, 2000; Wiersma, 2007; Foner, 1995; Henderson, 1995; Paterniti, 2000; 2003; Mali, 2008). These studies have examined the different aspects and nature of the power culture in these homes, including structures and routines and everyday life in them. Wilkin and Hughes (1987) argue that induced dependency is universal in care homes. They argue that, upon entering them, independent adults enter a state of total dependence generated by the institutional life, which is manifested in "a complex mixture of feelings: gratitude, resentment, resignation, powerlessness, acceptance and dependence" (Wilkin and Hughes 1987: 175). Booth (1985) critiques institutional living of older people, using induced dependency theory: "The more [that] institutional regimes deny residents control over their own lives, the more they tend to foster their dependency" (Booth 1985: 3). Willcocks *et al.*, (1987) extend induced dependency hypotheses by emphasising the dislocation involved in becoming a resident. Drawing on Tobin and Lieberman's (1976) study of selection policies, pre-admission factors, and environmental discontinuity, Willcocks *et al., (1987)* identify the potential loss of choice and control as the starting point for the older person when he or she first comes into the home. They conclude that although their study lacks the

data to confirm the findings of Tobin and Lieberman, anticipatory socialisation and institutionalisation cannot be ignored in the analysis of institutional effects on residents (Willcocks *et al.,* 1987:33). Their approach contrasts the lack of importance attached by Booth to anticipatory socialisation – because Booth is only attempting to measure post-admission processes – and extends the process of institutionalisation back into older people's life to the point at which a decision is made to apply for residential care. Institutional living is regarded as exacerbating the process of dependency already initiated by the time the older person crosses the threshold of residential care.

Diamond's (1992:126-127) in-depth study of life inside a care home suggested that the residents' identities were erased as a result of institutional rules and regulations:

> "….. Day and night as boxes got checked and records reviewed, these people were entered into the administrative language and codes of what services were rendered to them. In turn, these terms and categories and codes came to be viewed by many staff and outsiders as the ultimate reality itself, rather than a small part of it. …These documents did not merely reflect needs, they defined certain needs as well, and they erased others. Most basically, they erased the identity of the people whom they described as being social actors. The women and men living here did not write in these documents, nor did they read them. They did not speak in the charts. They were spoken about…."

Diamond (2000) argues that power structures in care homes are a result of the medical model of care work followed in the homes as opposed to the person-centred care model discussed in my literature review. According to Diamond, the medical model is reflected in the formalised hierarchy of care work and the domination of medical tasks combined with neglect of other tasks. He claims that this model is so deeply interwoven into the everyday life of care homes that it has the capacity to negatively influence older people's health and therefore work in a self-contradictory way. On similar lines, Paterniti (2000) in her ethnographic study of care homes found that care work was limited to bed and body work. The time-table and the number of tasks to be completed allowed staff little time to attend to residents' psychosocial needs. Thus residents are viewed as routine work, and the routines are scheduled by

the workers' agendas. As such, any self-definition by the residents tends to be dismissed.

Henderson (1995) also claimed that psychosocial care was dehumanised within a care home. According to him, because of the pressures of time and task, a superficial type of social interaction between residents and staff occurred, the ultimate result being lack of psychosocial care. In keeping with the above arguments, Patterson (1977) suggested that staff saw residents as work objects and developed work routines accordingly. The work objects were then theorised in order to explain and rationalise practice.

Various studies have looked at the ways in which staff develop and operationalise theories about residents and their work generally. Paterniti (2003) expounded on the constructions of residents by the staff and how staff related to residents by their specific categories of deficiencies. Patterson (1977) and Gubrium (1975) used an interactional theoretical perspective where staff members are seen as developing and using a set of theories or typologies about their work which are then reinforced and modified according to daily practice. The residents there were categorised according to the trouble they made for the staff in completing their work. These studies suggest not only that staff developed theories about their work which inform their day to day work but that theories can differ considerably whilst routines can be adhered to. The fact that the staff view their world and act on it in a particular way has immediate and concrete consequences for the outcomes of care and ultimately the experiences of residents.

Other authors criticise induced dependency theory in relation to care homes. They suggest that this theory ignores the structural dependencies created in societies. Townsend (1981), for example, argues that dependency in not located within the power structures of the care home but in the context of the wider inequalities experienced by older people generally. This perspective conceives dependency as a relationship between older people and the State which is mediated by the labour market and social policies in such a way as to create unnecessary dependence (Estes *et al.,* 1982; Guillemard 1982; Phillipson 1982; Walker, 1982; Townsend 1981; Estes 1979). Townsend argued that:

> "…. society creates the framework of institutions and rules within which the general problems of the elderly emerge and, indeed, are manufactured. Decisions are being taken every day, in the management of the economy and in the maintenance and development of social institutions, which govern the position which the elderly occupy in national life, and these also contribute powerfully to the public consciousness of different meanings of ageing and old age." (Townsend, 1981:9)

The structural dependency theory thus argues that society devises for its elders, either deliberately or unknowingly, a form of structured dependency. The implication is that older people are dependent, whether or not they enter residential care, because of economic and social structures in the wider society that foster dependency in older people. In describing how the process of structured dependency works in relation to care homes, the claim is that "socially, then, institutions are structured to serve purposes of controlling residents" (Townsend, 1981:9). This argument points to care homes inducing further dependency in older people because dependency is realised and reinforced through structures operating within it. Thus, my study is an attempt to analyse care homes' contribution to the degree of dependency (*dusreachea khalla assop)* through thier overarching rules and regulations which limit personal choice (*ichha)* and autonomy (*aplo adhikar)* in residents – that are absent or minimal in the world outside.

However, as noted in Chapter 2 (see page 24), Davies (1989:79) argues that viewing "total institutions as oppressive and opposed to the individual" is a distinctive feature of western societies. He bases his argument on the illustration that in non-western societies like India, care homes can be less authoritative and allow more freedom than the joint family so that the experience in a care home can be considered as a liberating one. He also argues that the idea of bounded space is very central to the concept of total institutions (Davies, 1989). Having said that, the whole bounded entity of care homes with their regimented rules and life patterns seem to conform to characteristics of total institutions which are limited in the case of joint families in India.

The analytical strategy being pursued in this chapter draws on the above theoretical discussion and Mary's account at the beginning of the chapter. I begin with the premise that induced dependency existing in care homes leads to passive

recipients of institutional control. Through the accounts from staff, residents and managers and their analysis in the sections below, I will illuminate the workings of dependency among the residents within the framework of power. I have sought to capture them in three aspects: group living philosophy, rigidity of rules and regulations, and staff and management practices. They all intersect in practice and together present a picture of the impact of institutional power structures on the residents. In the rest of this chapter, I will attempt to provide new insights into the residents' everyday lives through exploring the themes that were crucial to them. Thus the stories of the residents, staff, and management will be interleaved within thematically organised sections containing brief accounts and incidents. I have included the range of responses gathered from all the three homes within these thematically arranged sections.

The analysis will emphasise the forms of *formai* (controls) in care homes in Goa that induce dependency in residents. As we shall see, these controls deny residents the opportunity to make ordinary choices about themselves. These forms of domination are institutionalised means of extracting subordination and expected behaviour from residents. Thus I am concerned with the institutional options that are aimed toward the care of older people but may (inadvertently or advisedly) culminate in the control of residents in the care homes.

7.3. Group Living philosophy

Control and its impacts in the three care homes I studied were observed on a daily basis during field work. Institutional rules and regulations *(nem ani kaide)* in all three homes (though varying in intensity) were designed in a way that treated residents together as a *zomo* (group) before, during, or after any specific activity. It was characterised by residents getting up at the same time every day and doing things in a conveyor belt fashion, thus implying the lack of residents' individual *iccha* (choice) and *adhikar* (autonomy) in participating in an activity at their own pace. The residential setting thus displayed certain *xokti* (power), and the practices of residential caring can be seen as forms of *formai* (control). This implies a loss of rights *(hok)* and choice (*iccha*) over the way that residents spend their day; how they use their personal time, what they eat and when, with whom they engage in conversation, and how they present themselves. Such lack of *ichha* and *hok* over

one's own decisions depersonalises individuals (*monxak kirkoll korop)* and undermines individual identity (*osmitay*) and dignity (*mann*)

In delivering care to large groups of residents, the influence of the organisation is stronger than that of individuals and can overwhelm the capacity of residents and staff to individualise and protect key features of a personal lifestyle. The accounts below demonstrate that the routines (*chali)*, rules (*nem),* and everyday practices (*riti)* through which the residents were cared for in groups (*zome)* were related to staff and management convenience rather than the needs of the residents. Staff and management claimed that group management of residents in terms of getting up and bed times, and meal times, was inevitable in caring for residents in care homes. Furthermore, staff pointed to the vast number of tasks that have to be completed during their shift. To enable quick performance of their tasks they found it very convenient to divide residents into groups. Examples of this were seen in the bathing and meal patterns. The residents in the Government and Religious Home were divided in *zome* (groups) and each *zomo* (group) had a day in a week or time of day allocated for their baths. It was a similar system with meals in all the three homes; residents had to assemble in the dining area at the same time across all the three homes. They were then supervised in groups by staff. Analyses of all the three homes showed no differences between settings in terms of the times at which the residents were asked to wake up in the mornings or went to bed – which had no obvious effects on staff tasks. Nor were there any differences between settings with meal times. Such practices (*riti)* thus were not only organisationally convenient, but also based on assumptions that residents are no longer capable of thinking for themselves, a viewpoint that is very paternalistic. Accounts from staff and management across the three care homes demonstrate this:

> *"One main rule (nem) in our home is strict adherence to meal times… the residents have to gather in the dining halls at 09.00, 12:30, 15:30 and 20:00…., they also have allocated spaces at the dining tables. It is important that they are limited to their allocated spaces; otherwise it would cause confusion in serving meals (as the staff have the meal quantity for each resident figured out and serve it at the spaces accordingly.)" (Field notes, Private home, September 2011)*

> *"…..for practical reasons we have to deal with the residents in groups (zomeani); otherwise, it would take forever for our staff to deal with 70 residents..…..." (Rahul, Assistant Manager, Government home)*

> *"We have a queue system during meals; a bell is rung and the residents begin queuing up near the serving table. The men come first and the ladies follow…this system works well for us." (Prabakar, Staff, Government home)*

> *"We cannot bathe them every day so we have groups allocated to each staff…these groups have different bath days…the residents are used to it by now, they know their days" (Lata, Staff, Religious home)*

> *"A bell is rung during prayer, meals, and bed times, and all the residents act accordingly. This is a good system to which they respond…and it allows daily routines to run smoothly."(Jeanette, Manager, Religious home)*

> *"We have to treat them equally. For example, the other day a resident wanted to eat in his room but we had to tell him that he has to eat in the dining room…there are two reasons. First, once you allow one person to do so, then others will follow suit. Second, it is easier to supervise them in the dining room than individually in their rooms. It would take all day to supervise them individually..…. (Lucy, Staff, Religious home)*

The above accounts from the staff and management reflect the institutional philosophy following in the three care homes – group living. *Zomeani ravpachi rit* (group living philosophy) was not opposed by the residents. My interviews with the residents revealed that they enjoyed the experience of living in a congregate environment which was not unfamiliar to them given their past experiences of living with big families:

> *"It is nice to be eating together. It feels like a family just like back home. It may not be my favourite dish everyday but every once in a while you get it." (Mary, Resident, Religious Home)*

> *"It is not a big deal to be sharing with others. We do it in our homes. I have eight children and all of them are married and have at least three kids each. When we were all together we needed to share a lot and it is like the same thing here." (Gopi, Resident, Private Home)*

> *"It is nice during supper here. The men lay the tables and women serve. I really like it, it is similar to during festival times at home." (Arjun, Resident, Government Home)*

> *"If there are no fights in the dormitories, we are happy. We make fun of staff and gossip about residents in other dormitories." (Laxmi, Resident, Government Home)*

For these residents, this past experience of living in such a congregate environment was seen to be important and relevant to their accepting the communal way of living in the care home. These residents also discussed meeting collective needs in relation to the Indian culture of living and eating together as a joint family. In Indian culture communal living (*somudayik jinnem*) as demonstrated through the joint family is valued and seen as a platform for values such as cohesion, and cooperation, which foster an interdependent sense of self (Matsumoto and Juang, 2012). These values seem to have influenced how some residents in this study handled the difficulties arising from living together and sharing common facilities (Lee, 2001). The problems in the experiences of communal living (*somudayik jinnem*) arose when the group living philosophy (*zomeani ravpachi rit)* impacted their attempts to live a normal life and ignored the resident's *iccha* (choice). Elders in Indian society have been valued for their experience and wisdom; they are consulted for advice, support, and resolution of family and community issues. Respect for tradition, including the hierarchy implicit in social relationships, is the norm (Choudhry, 2001). The residents in my study found this aspect compromised in their everyday living in the home. Hence, though the Indian values of collectivism (*somudayik jinnem*) enable them to remain open and to accept the communal way of living, these same values when demonstrated by the staff also serve to conflict with the Indian tradition of valuing old age. The overarching reflection was that this collision of Indian values in the minds of residents' values led them to experience residential care negatively.

Group living philosophy *(zomeani ravpachi rit)* led residents being seen as passive and accepting and as a homogeneous group needing the same kind of care. This philosophy was not restricted to the residents' bed and meal timings. It also pervaded their dressing style and personal getup in the homes.

> *"Our residents always wore green uniforms for they are easy to identify and spot. However, now because of lack of funds we find it difficult to have uniforms for all…so we provide them with donated clothes." (Savita, Staff, Government home)*

> *"The barber (malo) comes once a month to cut their hair. He does the men's first and then the women's….He gives everyone a boy crop…So the problem of lice is tackled…" (Isabel, Manager, Government home)*

> *"Men need to have their trousers and half shirts on and women dresses or skirts and blouses when they are out of their rooms. Half pants and nightdresses are not allowed outside their rooms" (Jeanette, Manager, Religious home)*

> *"The common practice was that men wear trousers and shirts and women saris; neither the manager nor the staff demanded the resident to do so but it was seen as an expected norm…" (Field notes, Private home, September 2011)*

Thus, institutional group routines confronted residents as an overarching reality across all the three homes. This philosophy deters individual choice (*iccha*) and induces dependency (*dusreachea khalla)* in residents as passive followers of the routines established by the institution. By encoding the staff and management expectations and the convenience of residents' care and by defining within limits more or less precisely who does what and when, the daily group routines structure the residents' daily experiences. Group living philosophy *(zomeani ravpachi rit*) fixes both the pace and pattern of their everyday lives. It has a negative impact on the functioning of residents, for the outcome hinges on the scope of autonomy (*aplo adhikar)* accorded to them. This can foster dependency and divest the residents of responsibilities for the performance of routine personal chores and tasks which in turn hastens the loss of abilities.

Interviews with two residents pointed to the justification of the group living philosophy in the care homes. Residents in their accounts illustrated below indicated the reality that they are in the home so as to be cared for, and hence the group philosophy is the most appropriate:

> *"I am here because I could not take care of myself and neither could my family. There are 46 others just like me. So these routines and stuff bring around some order… It is*

organised care, the staff take care of us, they are meant to. We have times for bath, eating and the like." (Mary, Resident, Religious home)

"This system of gathering five times at the dining area brings around more equality…It applies to everyone alike….just because you have money or something you cannot ask for preferences here…Everyone is treated equally…that is what I like about it" (Arjun, Resident, Private home)

These explanations reflect the rationale of residential care – that is, it is a place in which care is provided. The point to be made, is that, in this group living philosophy, the collective can overshadow the individual, and for the residents to be seen as passive and accepting and as a homogenous group needing the same kind of care. This aspect of group living can negatively impact the everyday experience of residents in care homes as will be illustrated below.

Interaction with the majority of the residents reinforced the above argument while the residents themselves reflected the need to 'live a normal life', to be included in the decisions about their daily routines, and to contribute to the community and society they live in. Research suggests that this continuance of living a normal life as one lived before entry to an institution helps to maintain a sense of personal identity. Tobin (1991) proposes that in an institutional setting, living a normal life can be a major everyday struggle. In delivering care to a large number of residents, the influence of the care home is relatively stronger than that of the individual, and can overwhelm the capacity of the residents to live an individualised life-style. The accounts below demonstrate how group living philosophy in the three homes I studied hampered the resident's everyday choices to live a normal life and perform mundane tasks.

"Long hair was a part of my identity (osmitay) of being a woman (ostori). They will never allow us to grow our hair here, we have to crop it boy cut (chedea baxen). It is a barber (malo) who comes and cuts it for me, there is no shape, no haircut. He just cuts it unevenly. I feel so ugly (halsik). I loved keeping myself well. When I was younger my hair was so long (shows length)." (Milena, Resident, Government home)

They call in a barber once a month. He (Barber) cuts our hair in the same way he cuts the men's. We are not even asked whether we need a haircut. I hate it but what can I do.

We all look the same, the only difference is they wear pants and we wear dresses." (Alice, Resident, Government home)

"I do not get good sleep at nights and in the mornings I cannot wake up. They (staff) come to wake us up at 6.00 am. I feel sleepy at that time. They shout at me and remind me that I am not in a hotel and get me out of bed." (Milena, Resident, Government home)

"I am a machine here, which is operated by the staff…All my decisions are taken for me. I am told when to eat, bathe, and even go to the loo, and I do accordingly… (Felix, Resident, Religious home)

"Here, you need to go to the dining area five times a day and have your meals there…if you say you want to have them in your room the staff would say, 'we cannot do it as others will begin asking for it.....…" (Rajan, Resident, Private home)

The *iccha* of cropping hair, waking up, and having a bath was something basic and a loss of this could well be seen as a hindrance to maintaining personal choice and autonomy. Langer and Rodin (1976) and Schulz (1976) argue that the perceived lack of control over the details of one's life is injurious to physical and mental health and is positively associated with and, ultimately, mortality.

Another important element which contributed to the residents' mechanical following of the rules included the feeling of stability and security, and of having a roof over your head permanently. This overpowering and overwhelming feeling impacted the residents' daily activity in the home. They acknowledged their helplessness in the accounts below:

"…I do not like going to the dining room five times a day and I like to have at least some meals in my room. If you tell them you do it they will say, 'if you cannot manage then you need to consider moving into the hospital that the home runs.' (Sheetal, *Resident, Private home*)

"….day by day this place is getting bad, now you cannot even utter a word against them (management). If you say that you do not want something or you ask for something else, these nuns would say, 'if you cannot live like everyone else and you need personal service then go home!' For example, they tell us to close the room windows after 6 pm, and if I am in my old world praying or something like that, they will get upset and tell me to go home. Every time I hear go home, go

> *home, it is so depressing, It makes you very insecure." (Leena, Resident, Religious home)*

A similar experience was narrated by another resident, Reggie:

> *"You saw yesterday when I came out for breakfast in my night clothes – which I think is quite decent. She (manager) embarrassed me and said to dress decently like everyone else. Now I am not comfortable with trousers and shirts during meals and besides the dining area is outside my room….she will not understand….in fact she came with me to my room and got me changed into full trousers." (Reggie, Resident, Religious home)*

Feelings of insecurity combined with limited control over their personal lives destroy the present moment for the residents. This in many cases causes them to give in and follow the instructions of the staff and manager mechanically. Rules and regulations as discussed in this section imply the inflexibility of institutional practices: neither individual differences among residents nor unique circumstances are taken into account. This inflexibility provides a base for regimentation of the routine. Though this form of control is discussed as a separate section, it complements group living philosophy of the institution spoken of in this section.

7.4. Rigidity of the rules and regulations

The rigidity (*nisturai)* of everyday institutional rules and regulations (*nem ani kaide)* described in the previous section consolidates these practices (*chali)* into established routines (*riti)* to which residents had to conform. The rules and regulations impacted and structured the institution and the way that staff went about their day-to-day jobs (Diamond, 1992). Regimentation of work is justified by staff as a way of getting through their daily tasks. Residents in all the three homes felt constrained by the regulations of the homes they lived in. In this section I begin by highlighting staff and management views on regimentation and then proceed to discussing residents' experiences.

7.4.1. The Staff and management's view on regimentation

When the staff and management were questioned about strict adherence to the rules of the home, they were vocal in endorsing them. The rigidity *(nisturai)* of routines *(riti),* rule *(nem)* and regulations *(kaide)* and the reasoning behind it is illustrated below:

"We have to be strict with them. This is not their home, even in our own homes we have some kind of routine (rit)….we cannot allow them to have their way, they have to be the riti of this home." (Isabel, Manager, Government home)

During Lunch, a resident was seen seated in a seat allocated to another resident. The staff immediately reprimanded him and asked him not to disturb the order of the place. She said "You need to pay some attention to the rules and regulation if you want to live here; this is not your home." (Field notes, Private home September 2011)

"Our rules are strict but there is a reason for that: one, to make things convenient for us and second, for the safety and wellbeing of the residents as a whole. It is like a win – win situation. See for example, it is not that we lock them up or do not allow them to go out. If their families come and take them, we are very happy to send them. Why should we stop them? We do not send them on their own because if something happens on the way, the manager needs to face the problem and then the whole Provedoria department will come under the scanner. Even when they go to hospital we send them with a staff, never alone…." (Rahul, Assistant Manager, Government home)

"We need routines (riti), rules (nem), and regulations (kaide), right? Otherwise how can we run a home? Do you not have a routine in your personal life: would it not be chaotic otherwise? That is why residents are expected to behave according to the rules and regulations of the home…" (Karuna, Manager, Private home)

"Residents are happy when they are left in a settled routine; anything out of that instigates tensions…so it is not only that we want these routines, they also prefer it." (Jeanette, Manager, Religious home)

"The residents have everything done for them. If they have to make a few compromises, they should do it willingly….a few rules and regulations, that is it." (Lata, Staff, Religious home)

"Residents were locked in dormitories all night and most hours of the day…the dormitories were opened in the morning for breakfast and remained open till lunch…they were locked after lunch and opened for afternoon tea…the dormitories were locked again after dinner till the next morning…the management claimed the purpose of the locking was the safety of the residents....there have been occasions in the past where residents have tried to escape,

hence locking the dormitories is seen as a way of preventing this…." (Field notes, August 2011, Government home)

The above accounts show that the resident is seen as important across all the three homes but the best technique of caring for a resident is control. As the Assistant Manager in the Government home pointed out, rigidity of the rules and regulations was *'for the residents' good and wellbeing'*. Locking up the residents and expecting strict adherence to routines does not leave scope for individual choice, the result being the passive following of the rules and regulation of the care home. These written rules and regulations were accompanied by general expectations of normal practice within the care homes which were looked on as unwritten rules and regulations. For instance, though rarely mentioned, there was also the norm of no smoking and drinking alcohol. Thus the behaviour of the residents was controlled by both written rules and regulations and expectations of the staff.

Risk management in care homes is used as a common reason for the regimentation technique in restricting the residents' autonomy (Lidz *et.al.,* 1992). At all three care homes, residents were managed to avoid any possible risk in which they might be injured. Risk management was not only focussed on the individual, but also on the collective. By managing risk, residents were taught that their bodies were frail and old, and needed to be protected at all costs. As such, desires to maintain independence and personal care were disregarded as the staff set limits as to what the residents were 'allowed' and 'not allowed' to do. As the manager put it:

"W*e are a care home operating on the philosophy of care and independence, but independence all around issues of safety and risk" (Jeanette, Manager, Religious home)*

Thus risk management as an ideology structured the residents' day-to-day lives and experiences in intimate ways.

Flexibility of routines was seen as a negative characteristic by the manager or staff: The implication was that regimentation of routines, rules, and regulations were a necessary quality for good managerial and staff practices.

"One has to put a fright (boi) in them (the residents) and then they will be put in the right place. Sometimes the manager says: they are old, we should tolerate their faults. But according to me, they should think about it before making the mistake, right? Why should we tolerate? How will

they learn…others will also follow" (Suraj, Staff, Private home)

"This Sister (manager) is good. She is very strict with them. The previous one was gullible: she would listen to whatever they say…she never corrected them…she was a very good human being but that does not count at a practical level, right…we have to get the job done here"(Raju, Staff, Religious home)

The rigidity of the rules and regulations played an important role in controlling the behaviour of residents across all the three care homes. This control created dependency in the residents. The way the residents were seen responding to prayer times, meal times, and wake up and going to bed timings was representative of dependency. These are discussed in the next sub-section.

7.4.2. Resident's voice on regimentation

Chapter 6 (see pages 154-157) highlighted residents' attempts to accommodate rules and regulations of the care homes in their everyday lives. In line with the same discussion, though residents in my study accepted the need for rules and regulations in the homes, it is the inflexibility of these rules and regulations that hampered a positive experience for the residents. Residents across the three care homes spoke about the inflexible controls to which their life was subjected.

"… They never ask what we want. For example, they never ask what we would like for a meal or what time we would like to have it. They do not even ask us whether we are comfortable with the way routines are organised for us. The timetable has been the same since I first came in, i.e. 10 years back. Nothing has changed. It is just dumped on us and we have to follow it." (Sunil, Resident, Private home)

"Here, to go for a meal, they first ring a loud bell and then they come in and tell you to gather in the dining hall. You get your lunch and they lock you in the dormitory" (Laxmi, Resident, Government home)

The other day Kareena (staff) asked me why I was in bed and whether I was not coming down to get my lunch. I said no. She got to a point where she was arguing with me. She said, "You are one down, if you miss it two more times, then you

will have to be moved to a hospital" (Sheetal, Resident, Private home)

The issues spoken of by residents in the accounts above indicate the degree of control (*formai)* and choices (*ichha)* older people have over their daily living in the three homes. The powerlessness of the residents in the above accounts fosters a mood of submissiveness and dependence. Other factors which further this feeling include lack of privacy and limited self-expression. For example, staff and management decide the residents' daily routines which they are expected to follow irrespective of their own preferences. The extent to which the care home has control (*formai)* over the resident's life-style is an important variable in analysing dependency in residential living. From the above accounts of the residents, dependency (*dusreachea khalla zavop)* can be interpreted as subjecting everything to the rules and regulations of the institution. This means being obliging to all demands and instructions and just going with the flow of what the institution demands. This makes the individual lose his individuality and become more mechanical in following the rules of the home.

Encapsulated in the accounts of the staff and management in the above discussions on rigidity of rules and regulations in the home are dependence (*dusreachea khalla),* power (*xoktti),* and care (*dekhball*). Whatever the reasons, the immense control (*formai)* from the use of these sanctions cannot be ignored. It became evident through some of the residents' comments that adherence to the routine was very important for staff, more important than the residents' wishes or requests. At times, adherence to routine created conflict between the residents and the staff. In the next section, I will discuss the patterns of social interaction between the staff and the residents as control was asserted, accepted or resisted.

7.5. Social distance in staff-resident relationships

As noted from the discussions in the previous sections, routines and regulations dominated everyday life and staff care practices within the homes. The result was a degree of separation between the residents and the staff, with the staff being in control of the residents and their behaviour. In the process of my fieldwork, reflection of this power relationship was evident in four aspects of staff-resident relationships: the staff's preoccupation with physical care of residents, the staff's

theories about residents, staff technique to control resident behaviour, and the staff's manipulation of residents' relationships within and outside the home. The sections below detail these four aspects as manifested in the accounts from the staff, management, and residents.

7.5.1. Staff preoccupation with physical care

Staff-resident relationships in the home were characterised by limited conversation between the two. Residents felt that the staff were too busy to talk to them and related to them only formally. The management and the staff felt that talking to residents was not a legitimate part of their care-work in the care home. For the staff the residents became bodies to be washed, to be fed, and to be taken to the toilet. This view found justification in the staff's accounts of how to get through their daily tasks. Their daily tasks revolved around the residents' routines and body care. Staff focussed on the residents through the various tasks they had to perform. The accounts from the staff and the residents illustrate the above views:

> *"…we do not have time to talk to them….. If we talk to the residents, we cannot finish our work and the Manager will scold me…." (Kareena, Staff, Government home)*

> *"I do not even know the names of the staff. They come to do their job and go. They do not know our language. Sister (manager) talks to us when she has time but she rarely has. She is so involved in the work of the village and parish that she has no time for us." (Leena, Resident, Religious home)*

> *"Our contact with the staff happens only in the dining area and when they give us medication…..they come in the morning to get into their work and by 5.00 pm they are hurrying back home to their families…they have a very tight schedule. (Sunil, Resident, Private home)*

The above accounts illustrate the relations between the staff and the residents as very restricted as a result of the staff's overt concentration on physical needs, busy schedule of the staff, and language barriers. The management across the three homes played an important role in enforcing the tight schedule of daily tasks to be completed. In doing so the management not only negotiated the staff-resident relationship within the home but also determined the outcome of this relationship: a

power relationship between the staff and the residents where the staff are in the dominating position. The accounts below demonstrate these complexities:

> *"I am very strict with the staff, I make sure that they do not waste time chatting with the residents. They can do it if they finish their daily task which is not possible…I also have to think of the staff on the next shift, they should not be overburdened….I ask the staff to be strict with the residents for the same reason…." (Isabel, Manager, Government home)*

> *"Our work revolves around the residents' eating, sleeping, changing, toileting…..anything other than that is questioned by the management and now we too question it ourselves…" (Kareena, Staff, Government home)*

> *"Now see if the residents come to me and complain about being ill-treated, I do not know how to react. If I reprimand the staff, they will think I do not trust them. We need the staff, right, and I also trust my staff. If I catch any staff red-handed, I will take action but otherwise no…." (Jeanette,Manager, Religious home)*

> *"We like people coming in and talking to the residents during our visiting hours. We cannot do much in that line, we can only give food and shelter. Our staff are very busy" (Rahul, Assistant Manager, Government home)*

The structure of the institution, with its rules and regulations, and organisational issues were used as reinforcement by management through the staff for dependent behaviour of the residents. This section portrayed how nonverbal actions of the staff maintained and fostered perhaps inadvertently and unknowingly a dependency culture for the residents. Dependency (*dusreachea khalla zavod)* among residents in the care homes was reinforced by the verbal actions of the staff, discussed in detail in the next section, as the staff typified positive and negative descriptions of the residents – their work objects.

7.5.2. Labelling residents

Everyday care practices in the homes by the staff revolved around typifications about the residents and their implications in terms of routine and behavioural requirements of the residents (Hudson, 1987). Patterson (1977) in her

study of old people's homes argued that the staff use these typifications to interpret and understand their work with the residents:

> "[they]….serve not only as guides to management of routines...but as an explanation and justification of events". (Patterson, 1977: 121)

The idea of inevitable decline underpinned the general typification of residents across all three care homes. A slow and inevitable physical and mental decline in the form of increasing incontinence, confusion, and immobility was an expected part of the residents' behaviour. This expectation meant that signs of decline were not just predicted but also often found. Interaction with the staff illustrated in the accounts below pointed towards this categorisation:

> *"It is not easy to teach this lot anything new. It is not possible to get them to do anything. Half of them are mad. Mind you, the other half should not be here…" (Lucy, Staff, Religious home)*
>
> *"It is difficult to teach old dogs new tricks, right. Similarly the residents are too set in their ways. They would not be able to comprehend much now" (Rahul, Assistant Manager, Government home)*
>
> *"We try to organise functions, celebrate festivals and the like but, being old, it is too much for them….. Hence we have reduced these functions now…." (Vishanti, Staff, Private home)*

The staff theory of inevitable decline attempted to justify the inactivity of the residents in the care home. It also excused the lack of innovative care from the staff. Resistance to decline was based on resistance to additional work rather than helping residents to maintain themselves at a more independent stage.

Peppered through my fieldwork were instances where typification of the residents could not be understood through the lens of inevitable decline alone. Jeffery (1979) argued that in casualty departments, patients were categorised as 'good' and 'bad', with clear consequences for how they were treated. Staff in long term care settings label residents so as to control and manipulate their behaviours (Hallberg *et al*., 1995). Similarly, in the three homes that I studied, specific categorisation of residents was used in the everyday accomplishment of care. Though *'dekivont'* and *'mosto'* ('virtuous' and 'troublesome') were categories generated by the staff to label

good and bad residents, they did not always use these terms. In their interactions with me, they made comments like *'this is the kind of resident I like caring for'* or *'he (indicating a resident) is mosto…these sort of people make work difficult'*. The tendency was to perceive residents' behaviour in terms of difficulty or handicap. This categorisation guided staff care practices in such a way that conditioned the residents' behaviour. Below are the most popular characteristics of these categories.

Ungrateful *(Anupkari)* residents

The staff expected the residents to be verbally grateful for everything the staff did in the care home. They anticipated repeated *'thank you'* from the residents. Residents who were sad and cried were seen as unpleasant to work with. Unhappy residents were seen as ungrateful:

> *'I once noted a staff admonishing a few residents at the end of a shift. She told them that "it might help if once in a while you thanked us, since our rewards so far are only cleaning up stools"' (Field notes, Private home, September, 2011)*

> *"Some of them have no gratitude. We do so much for them; their own families have kicked them out. They do not even smile in return but sit with mourning faces as if someone has died. They must have done the same thing at their homes and hence they have been admitted to this home. That is the reason they have no friends here, they will always be bored and lonely." (Ramanand, Staff, Government home)*

Demanding (*Magpi*) residents

Residents who continuously sought attention or help were seen as demanding. Their demands were seen as petty and unreasonable. The residents were automatically denied by the staff and repeated calls from them were turned down. Their acts therefore became one of nuisance and the residents became characterised as demanding, dissatisfied and annoying.

> *"Carmen is so demanding…keeps asking for painkillers or something or the other…we ignore her sometimes but other times we tell her off and let her know she has gone too far."(Kareena, Staff, Government home)*

> *"They get everything when they need it, they do not even have to work for it…but still they are not happy, they keep asking for this and that – selfish and greedy….I do not give into their frivolous demands and instruct my staff not to either." (Jeanette, Manager, Religious home)*

Ill (*duent)* residents

The staff had a clear distinction in their mind about the care home being different from a nursing home. They had the impression that '*only healthy old people'* should be admitted to the care home.[26] Hence residents with severe medical conditions, particularly those with permanent pains (arthritis), weak bladders, dementia[27,] and severe heart conditions were categorised as the 'bad residents'. The inherent reason was that these medical conditions added to the day's tasks which needed to be ticked off at the end of the day's shift.

> "*That Alice has such a weak bladder, she keeps urinating and adds to our work."(Savita, Staff, Government home)*

> *"Ignatius has arthritis and because of the pain, he keeps falling. He must have done bad things and that's why he suffers for it. Anyway that is not my problem; my problem with him is that he needs more help than others; we need one staff member just for him. Hence, we have one pair of hands less to finish the routine tasks." (Pramila, Staff, Religious home)*

Unclean (*meye)* residents

Cleanliness of the residents played a big role in determining the type of residents. Residents who neglected their cleanliness and hygiene were always seen as the 'bad residents'.

> *"Some of them are a dirty lot. They do not like taking a shower. They do not like changing their clothes. I can't imagine how they brought their children up. Just see how smelly they are. This makes our work unbearable. At times we have to just tear down their clothes to force them to change. But we can only do so much; eventually they are going to rot and die if they do not take their own hygiene seriously" (Gabriel, Staff, Government home)*

> *'During one of my field visits at the end of my participant observation, I noticed a staff, Ellama, tearing the clothes off Seema and forcing her to put on a clean pair. Additionally, Ellama forced Seema out of bed and left her on the floor,*

[26] Their impression was justified by the home's admission policy which required the resident to be mentally and physically fit on admission.

[27] Dementia was not recognised as a medical condition in some instances but just a sign of old age. Other times residents with dementia were deemed as 'mad' or 'mental cases' by the staff. This is not reflective of the staff personal traits but the culture of the home which lacks training for the staff.

changed the bed sheets and got Seema on the bed again. She grumbled all along as she did this' (Field notes, Government home, September, 2011)

The staff's perceptions were influenced, explicitly and implicitly, by their interpretation of what constituted acceptable behaviour. The hostile and unflattering labelling of residents acted as a tool to alter the behaviours of the residents. The staff not only used these labels while talking to each other about the residents but also addressed the residents with these labels. Consequently restraints were often applied as a form of sanction to limit the behaviour of the residents so that it made sense to the staff, in order that they could construe it as 'normal'.

7.5.3. Controlling residents' behaviour

The techniques used by staff to control residents' behaviour were both verbal and physical. The temptation was to associate the physical dependence of the residents with a need to control. The consequence was that the residents' feelings were treated as small matters, sometimes indulgently, sometimes abruptly. As illustrated in chapter 3 (see page 66), the incident below is an example of this treatment:

'Jaunita was verbally abusing a fellow resident. Savita had scolded Jaunita, given her a smack and forced her into bed. On this day Savita and I were having lunch together. I casually asked her about the incident and she told me that this is her disciplining technique. She said that this is their second childhood, so like children they should be reprimanded when they do something wrong'. (Field notes, Government home, September, 2011)

Another incident occurred with Jaunita a week later which had even more dangerous fallout:

'When I came in at 10: 00 am, I noticed that Jaunita was not in her bed. So I asked other residents about her whereabouts. They told me that she had been shifted to the mental dormitory since she was involved in verbal fights with other residents. They also told me that she would be brought back the next day. The staff reiterated the same. The next day when she was brought back, I noticed that Juanita had an awkward silence around her. She was bruised (probably beaten by the mental residents). She did not speak to anyone. During lunch I confronted the staff on this matter. They did not defend their position; in fact they justified it. They told me that the same

> *correction therapy was used by Sarojini i.e. the need to instil good behaviour by punishing bad behaviour. They also told me that this was done so that the majority of the residents were happy, since almost all were against Juanita. (Field notes, Government home, September, 2011)*

There were two issues emerging from the incident: one was with regard to the correction therapy used and the second related to sacrificing individual happiness/care/freedom for the sake of the group.

> *"When I asked Sarojini about the above incident she, without a blink, said: Yes, we put them there when they fight or are stubborn. The reason for that is that they will be frightened and do not do wrong again (boi lagpak). That dormitory is a bit scary, right, people keep screaming and some of them even hit others, so we keep them for one day and bring them back the second day. I will give you an analogy of how it works; see, you have to pamper children but at the same time you have to scold them when they do wrong, if they are pampered always they get spoilt. At the same time if they get whatever they want, they go on asking for more and there is a time when they start asking for bad things, at this time you should scold them. You must always give them what is necessary; if you make them used to all luxuries they will get spoilt. So you should keep them in place from the beginning. In the same way for these old people, if they are taken there for a while they will have the fright that if they do mischiefs they will be taken to the mental dormitory so they would not say or do bad things. In this way we train them to become good and to be in control." (Field notes, Government home, September, 2011)*

An incident occurred in the Government home (mentioned in chapter 3 pages 57-58) during my field work which can be used to further explore the strategies the staff adopted to control residents:

> *There followed an incident with Carmen (resident) as she was walking back to her room after lunch. She has arthritis so she could not walk fast, and she kept telling the staff she needed to go to the toilet. Two staff helped her with her plate and led her to the toilet. However, before she could enter the toilet she did it all over the floor. The staff were annoyed about it (quite naturally). One of the staff mopped up the mess. Carmen kept apologising. It is not particularly relevant that the staff were annoyed with her except that this indicates a mild form of what the staff have to put up with all the time. The apology of Violet is a manifestation of how helpless she*

was feeling. She was then led to her bed; there she continued apologising and eventually wept herself to sleep. The staff did not say a word during the entire event. Their silence spoke of their frustration. She would not get up for her evening tea. Two staff came along and tried to get her out of bed. They tried the 'Come on girlie, you are doing well' approach. (Field Notes, Government home, August 2011)

Three kinds of methods of encouragement were usually used. The soft soap approach as above, the *'if you don't get out of bed on your own, I'll will force you to do it'* approach i.e. the hard approach, and a middle approach i.e. by saying to another resident: *'X is a bad girl, she does not listen to me; Y is a good girl as you listen to what I say and do it'* approach. This is coupled with staff labelling which goes on to define the staff-resident relationship. Seeing the residents as 'too old and infirm to be expected to do anything', was used as an explanation by the staff and management to defend their infantilising and dominating actions. The staff-resident relationships are actually largely power relationships. The implication is that the staff and the residents have different points of view and may come to perceive each other in narrow, hostile, stereotyped ways where the staff feel superior and righteous in contrast to the feelings of being inferior, weak, blameworthy, and guilty expressed by the residents.

7.5.4. The Residents' interpersonal relationships

Interpersonal relationships among the residents differed between homes but on the whole, these interactions were generally controlled in all three care homes. The control of interpersonal relationships was manifested in two forms: controlled relationships between men and women, and random allocation of roommates and dorm mates. The accounts below give evidence of these interactions:

On one occasion Milena went to have a chat with Gonsalves who she claimed was from her neighbouring village, outside the male dormitory. She was heavily reprimanded by one of the staff servants. When she went upstairs she was taunted by one of the female servants Kareena 'This is disgusting, how can someone think of flirting at this age'. Milena withdrew and went to sleep (Field notes, Government home, August, 2011).

"They are not allowed to visit each other's room though they are allowed to mix in the dining and living room…but they separate naturally" (Jeanette, Manager, Religious home)

"Having men and women separated particularly in rooms is very convenient…otherwise we would have problems with bathrooms and toilets" (Jeanette, Manager, Religious home)

This principle of segregation was seen as a natural separation occurring in the homes by the staff. A major consequence of this in the Religious home and Government home was the separation of married couples. Segregation of sexes was not the only way in which opportunities for establishing normal social relationships was limited. Random allocation and transfers of the residents between rooms and dormitories by the staff and management acted as a mechanism for controlling relationships among residents. This allocation was made to increase convenience of the staff. With regard to the choice of roommate, the residents viewed control over their roommates' identity as crucial and were generally dissatisfied in matters relating to the choice of roommates:

"We try to put one healthy one and one weak one together as the healthy can take care of the weak" (Jeanette, Manager, Religious home)

"The residents are allocated to the dormitories according to the beds available. However, when there is a problem between two residents we do not like getting into it, so we quickly move one to the other dormitory." (Prabakar, Staff, Government home)

"We see whether they get along with each other for a couple of months. If there is no problem we keep them there; if there is, we will look for available beds in another room and shift one of them in it." (Karuna, Manager, Private home)

"I do not know why they have put me with this man….he is sick (duent) all the time….. I am like his carer; have to take him to the toilet, take him to meals etc…" (Felix, Resident, Private home)

"I just cannot get along with her……I wish I could choose with whom I could live…I told the manager but she says I have to learn to adjust as the problem is with me not her…" (Sarita, Resident, Private home)

"This dormitory is totally chaos…the reason is that they (management and staff) do not think about how they allocate

the residents to the dormitories….the residents are moved between dormitories according to the whims and fancies of the staff…"(Laxmi, Resident, Government home)

The above accounts appear to show that the residents preferred to have a choice and a certain degree of *formai* (control) over the choice of roommates or dorm mates they lived with. The present arrangement made an impression upon residents, who recognised their own vulnerability and dependence (*dusreachea khalla)* upon the arbitrary and sometimes vindictive decisions of staff and management.

7.6. Conclusion

In this chapter I have examined how residents in all three care homes were subjected to a system of rules and regulations (*nem ani kaide*), premised largely on a group living system (*zomeani jiyevop*) and layered with liberal use of management and staff discretion that dictated nearly all facets of their lives. In the analysis of extracts from fieldnotes and interview transcripts in the three sections I have pointed to an overpowering presence of institutional power (*xokti*) and control (*formai)* over the residents' lives in care homes in Goa. The residents are seen as passive recipients of these power structures – as witnessed in withdrawal or mechanical following of rules by residents. Though the intensity of subjection to rules and regulations may vary, its presence across all three homes was fully evident.

My findings in this chapter thus contribute to the literature regarding the controlling and regulating nature of care homes, and the standpoints of the residents residing therein. The theoretical starting point that the characteristics of induced dependency are found in care homes has been corroborated by identifying the presence of these elements. In doing this I have attempted to show that the resident's life in a care home in Goa is separated from life outside the institution. Intrusion into the resident's privacy is a common phenomenon. There is strict control by authorities over the individual's life, enabling a common life in a very large group of residents. This reveals a denial of privacy to residents, who have to share bedrooms and based on the medical model of care, rather than the normal expectations regarding the dignity and respect of residents. This model as seen from the findings of this chapter is not successful in realising the core values of independence, choice (*iccha)*, respects (*sammann)* and dignity *(mann)* for the residents. The three main factors

responsible are that firstly, the right of the residents to retain their choice (*iccha)* and autonomy (*aplo adhikar)* is contested by the management and staff. The residents' freedom of action in all the three homes was restricted through the imposition of rules and sanctions. Secondly, residents are not able to maintain control over their lives because the staff and the management eluded an understanding of, and a mutual respect for, the normal social conventions of privacy and respect. The residents did not have a choice, whether they would choose to spend time in the company of other residents or enjoy the privacy of their room. Thirdly, the residents are not responded to by the management as socially competent adults who were paying for (or contributing to the cost of) a service; rather, they were perceived as frail, vulnerable people who had been identified as needing to be cared for and protected like children.

In examining the dependency (*dusreachea khalla zavop)* that arose as a result of these controls (*formai),* rules (*nem)* and regulations (*kaide),* two distinct categories emerged:

(a) Those who submitted, seemingly without question, to the institution;

(b) Those who adapted in ways that allowed them to conform to the bureaucracy but still retain a sense of individuality only in ways that illustrated an awareness of the bureaucratic structure that facilitated their dependent status.

Both categories point to a sense of identity (*osmitay)* of the residents that is increasingly changing and becoming defined by the institution. This chapter reflected this experience in the post-entry experience. However, while the residents' identity could be correlated with stages of institutionalisation, there might also be emerging counter-identities that are concealed within the residents' silence, submission and everyday struggles. In other words, can residents as submitters also be resisters? In the next chapter I will explore the residents' survival strategies within the controls of the care homes, to have a closer look at their capacity as adults to make choices and enact personal agency – the other side to the post-entry experience.

Chapter 8: "They cannot boss me around": Manifesting agency

8.1. Introduction

> *"I feel I am at their mercy….it makes me feel so helpless at times… I cannot take their orders all the time so I pretend to be deaf as I need to survive here…" (Violet, Resident, Religious home)*

The previous chapter has constructed an image of the residents as being passive recipients of institutional controls, as the first sentence of the above vignette points out. Its focus is on what is done to them, not about what they themselves do, except when it comes to their limited interpersonal relations within the home. This conveys a picture of the residents as passive, of people just sitting and waiting to be cared for, with a sense of identity that increasingly becomes defined by the institution. Stopping the analysis here, however, would be inadequate. A deeper look at their adult capacity to make choices and enact the personal agency typical of adult status in society is vital for developing a holistic view of residential care in Goa (Morgan, *et al.,* 2006).

In reviewing my data closely, it became clear that the residents in care homes could be quite active. This point of departure acknowledges residents to be present in, and actively aware of, the setting, not just acted upon. In her expression above, '*I need to survive here'*, Violet brings out in essence the need to look deeper and explore the understandings and workings of agency *(virodh)* among the residents in care homes in Goa – what do they do to survive within the constraints and restrictions that the institution imposes? In answering this, I reflect on everyday forms of *virodh*, as manifested by the residents within the frameworks of power *(xoktti)* prevalent in the homes (Scott 1985).

It is by illustrating different forms of agency *(virodh)* and reflecting on them that this chapter gives a further dimension to the experiences discussed in the previous chapters. Residents attempt to resist institutional identities and create a personal identity (*osmitay)* that is not solely defined by the institution. They can maintain some aspects of self-identity within the institutional structures. This

evidence also helps in locating the presence of agency*)* which is manifested in everyday forms of resistance in the care homes (Scott, 1985). However I do not limit my chapter to locating the forms of resistance but go further to analyse the implications of these forms of resistance. The chief implication is that some forms of resistance are signs of "ineffectiveness of systems of power and of resilience and creativity of the human self in its refusal to be dominated" (Abu-Lughod, 1990:42). This insight allows for an exposure to the complexity of resistance and power relationship in care homes in Goa where systems of power are multiple and hence resisting at one level has the capacity to catch residents up at other levels. However, the significance of these minor forms of defiance should not be disregarded. Though the different types of resistance and manifestations of anger did not remove them from the power structures of the institution, it certainly allowed them to be agents within the limit of the context (Jeffery and Jeffery, 1996).

The chapter will begin with a broader theoretical discussion about self-identity (*osmitay*), power (*xoktti),* and agency *(virodh)*. The subsequent sections will then explore the different forms of agency by analysing illustrations from the field and drawing out their implications.

8.2. Self-identity, power, and agency

Everyday experiences support or compromise an individual's self-identity (Kellaher *et al.,* 2004; Hockey and James, 2003). If these everyday experiences take place against rigid structures which represent power, as we have seen in the previous chapter the outcome is the curtailment of the individual's self (Goffman, 1961). However, expressions of agency can carve out small spaces of autonomy, resistance, and defiance, and at times even help to reconfigure oppressive structures (Kabeer, 1999; Abu-Lughod, 1990; Scott, 1985). These expressions have the capacity to allow the dominated, – in the case of my study, the residents – to manifest their individual selves within the power relations and rigid structures of everyday life.

Mead (1934) was among the first to define the self as the product of social experience and activity. However, the notion that individuals can resist others' constructions of themselves and create new constructions of the self was not taken into account by her. Giddens (1991) in his theory of structuration takes further this perspective of self. According to him, the reflexive capacities of individuals are

involved continuously in the flow of day-to-day conduct and the social structure is seen as a set of rules that facilitates and constrains human action. Thus it does not make people do one thing or the other, but individuals decide what to do by drawing on the structure, thereby manifesting agency. Giddens tries to merge the self as a reflexive agent within social structures and theorises as follows:

> "Self-identity…is not something that is just given, as a result of the continuities of the individual's action-system, but something that has to be routinely created and sustained in the reflexive activities of the individual. Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood by the person in terms of her or his biography. Identity here still presumes continuity across time and space: but self-identity is such continuity as interpreted reflexively by the agent. This includes the cognitive component of personhood. To be a 'person' is not just to be a reflexive actor, but to have a concept of a person (as applied both to the self and others)" (Giddens, 1991: 52-53).

Bourdieu points at institutional structures that allow people to express their power differently (Gaventa, 2003; Bourdieu, 1986, 1984). Bourdieu, according to Moncrieffe

> "accounts for the tensions and contradictions that arise when people encounter and are challenged by different contexts. His theory can be used to explain how people can resist power and domination in one [field] and express complicity in another" (Moncrieffe, 2006: 37).

This helps to explain Bourdieu's concept of Doxa, which is the combination of both orthodox and heterodox norms and beliefs – the unstated, taken-for-granted assumptions behind the distinctions which individuals make. Doxa happens when we 'forget the limits' that have given rise to unequal divisions in society: it is 'an adherence to relations of order which, because they structure inseparably both the real world and the thought world, are accepted as self-evident' (Bourdieu, 1984: 471).

On similar lines, Gubrium and Holstein (2001) claim that the self is essentially a social structure, which unfolds in and through social life. Discursive environments function to assemble, alter, and reformulate ourselves. These discursive environments provide many options for who we could be. They set the conditions of possibility for subjectivity and

> "…are locally salient images, models, or templates for self-construction; they serve as resources for structuring selves. But as ubiquitous, prominent, and varied as troubled identities have become, the process of assembling them into institutional selves is anything but a matter of simply picking and choosing. Making connections between the personal self and a troubled identity involves a great deal of interpretive activity, work that is conditioned by the setting in which it is conducted" (Gubrium & Holstein, 2001:11).

Sabat and Harré (1992:455) state that the self of personal identity is

> "…experienced as the continuity of one's point of view in the world of objects in place and time. This is usually coupled with one's sense of personal agency, in that one takes oneself as acting from that very same point"

Identities are selves that are publicly presented in the episodes of personal interaction in everyday life (Sabat & Harré, 1992) or co-constructed roles that individuals take on in various social contexts (Small *et al.*, 1998). Usita *et al.,* (1998) did not explicitly define self in their study, but they argue that language is a reflection of self, and that information and stories which are told through narrative are also ways of making claims about the self. Cohen-Mansfield *et al.,* (2000:383) used an operational definition for the concept of self-identity in dementia that included "…roles, identities, attributes and preferences which an individual attributes to him/herself, and which therefore reflect selfhood". Charmaz (1983), in her study of the loss of self in the chronically ill, uses a symbolic interactionist perspective indicating that the self is fundamentally social in nature and is developed and maintained through social relationships:

> "When I speak of self-concept, I mean the organisation of attributes that have become consistent over time. Organisation is the key to understanding the self. Though the self is organised into a structure, ordinarily that structure ultimately depends on the processes to sustain it. In other words, for most individuals, maintaining the organisation of the self – that is, self-concept – means empirical validation in daily life" (Charmaz: 1983:170).

In this chapter I view 'self' as the continuity of one's point of view manifested by agency *(virodh)*, individual or group, when attempting to resist power structures. The implication is that though the residents were tied to the power structures within the home, they also attempted to shape their own fate (Jeffery and

Jeffery, 1996). Both Foucault and Bourdieu note that human identities are shaped, constricted, exercised, and socially signified – in short, constituted – through power relations (Rafanell and Gorringe, 2010: 614).

The implication of the above discussion is that the power *(xoktti)* of the institution to control the residents can be undermined by the residents' attempts at resisting institutional construction of self, and creating an identity (*osmitay)* different from that of the institution. As witnessed from the previous chapter, residential care settings exercise immense power and control over the residents' identities and perceptions of self through a range of prohibitions, restrictions, and regulations. According to Foucault (1977:95), "where there is power, there is resistance". At this point Foucault's understanding of the interplay of power and resistance becomes relevant. Rather than perceiving agency as a by-product of structural internalisation, he conceives of it as arising from processes of individual formation (Gorringe and Rafnell, 2007). The dependent thus do not lack agency but are rather constituted through an on-going process of power relationships operating through them. They are conscious agents and even though continuous power mechanisms dictate their practices and being, this is not false consciousness according to the Marxist claim. It emerges from the interactive collective where the individuals are conscious of being manipulated, excluded, and categorised. Thus, institutional power can be seen as resisted by the practices, beliefs, and performance of the dependent individual and the collective.

The forms of this resistance are myriad and include negotiation, deception, and manipulation (Kabeer, 1999). Scott (1985) argues that suppression and resistance are in constant flux. He speaks of the 'weapons of the weak' and the forms of everyday resistance through which the dominated and subordinate resist and challenge the structures of power that oppress them. These manifestations are typically mundane, spontaneous, and individual, as opposed to being highly organised rebellions. They may require little coordination or planning, and are used by both individuals and groups to resist. Resistance thus is a subtle form of contesting power structures by making use of "rumour, gossip, disguises, linguistic tricks, metaphors, euphemisms, folktales, ritual gestures, and anonymity" (Scott,

1985:137). It thus stops well short of outright collective defiance and instead consists of

> "minute acts of foot dragging, dissimulation, desertion, deception, false compliance, slander, sabotage etc.—actions typically identified as the weapons of the relatively powerless" (Scott, 1985: xv-xvii).

These actions do not cause revolutionary upheavals, but 'nibble away' at policies and practices which are subversive to their interests (Scott, 1985). Rather than confrontations that challenge the very basis of the system, these are attempts to work the system to their least disadvantage. In most cases they entail secrecy and deception. This implies that just as hidden forms of power *(xoktti)* in the form of institutional rules *(nem)*, routines (*chali)* and procedures (*prokriya)* can be used by the home to keep residents' issues and voices off the agenda, residents also can employ hidden strategies of resistance, behind masks of anonymity, euphemisms, or muttered grumbling which hide their actions from the powerful, or use codes to make them invisible (Scott, 1985). Scott's argument also challenges the Marxist view on false consciousness which asserts that internalisation of social norms can have negative effects on an individual's identity, which in turn leads to an unconscious compliance with prevailing structures as being authoritarian. He considers the thick and thin versions of false consciousness:

> "…The thick version claims that a dominant ideology works its magic by persuading subordinate groups to believe actively in the values that explain and justify their own subordination…..The thin theory of false consciousness, on the other hand, maintains only that the dominant ideology achieves compliance by convincing subordinate groups that the social order in which they live is natural and inevitable. The thick theory claims consent; the thin theory settles for resignation" (Scott, 1990: 72).

However, Scott rejects both these versions by claiming that there is more potential for resistance from subordinate groups (even if it is silent refusal to power, or imaginary rebellion), rather than whole-hearted belief in the systems that actually dominate them.

Ethnographic research has shown how through rumours, vulgar songs, answering back, and refusals, individuals (particularly women) have resisted the oppression of the framework of power within which they have to operate (e.g. Jeffery

and Jeffery, 1996; Abu-Lughod, 1990). Similarly, when talking about care homes, Gubruim (1993) showed the many ways (including blank stares and back-chatting) in which residents resist the pressure of conformity to the routines and the structure of these institutions. Paterniti (2003) in her research (on older people) found that storytelling, playing musical instruments, and illness, were used to transcend the institutional rhythms structuring their lives. In fact in some studies, voices of older people in residential care settings have been expected to hold greater influence than voices of the institution or kin over the major and minor elements of choice, such as control over personal space and daily routines (Carder & Hernandez, 2004; Golant, 1999).

These acts of resistance, as expressed above, do not however look to transform the existing order. In many cases they uphold and reinforces the status quo (Jeffery and Jeffery, 1996). Thus, the dominated cannot be viewed as helpless victims within an oppressive structure but neither can their agency be romanticised. Abu-Lughod (1990: 41-42) holds that the 'tendency to romanticise all forms of resistance as signs of ineffectiveness of systems of power and the refusal of the human spirit to be dominated, foreclose the possibility of reading resistance as a diagnostic of power'. This understanding enables one to locate the shift in social relations of power that influence the resisters as well as those who dominate. The structures which control, and against which the dominated resist, were also structures which sustained them and their wellbeing (Jeffery and Jeffery, 1996). Thus, the ideas of agency have to be understood within the duality of this framework. One should not exaggerate the potential of these acts of resistance to alter the framework of power within which they operate. Conversely, due to their lack of transformative potential, these acts should neither be rendered invisible nor considered unimportant. They will have to be considered on their own merit as expressions of agency within structures of domination.

Acts of resistance among the residents in this study were both individual and collective. They were played out in the dormitories, in dining areas, and living rooms. Through spending a prolonged period of time with them, I was able to see the various forms of everyday resistance unfold before me. They could be identified in some typical patterns of arguing, loud murmurings, ridiculing, deception, as well as

taking and executing some decisions which at a glance seemed counterproductive to me. Not all of these acts were invisible but often they became visible even in minute forms of struggle. Abu-Lughod (1990) argues that forms of resistance allow one to get at how intersecting and conflicting structures of power work together. She further claims that power cannot be treated as some sort of hierarchy of significant and insignificant forms of power. Doing this, according to her, may block one from "exploring the ways in which these forms may actually be working simultaneously, in concert or at cross-purposes" (Abu-Lughod, 1990:48). Through my ethnographic illustrations of the three care homes, I show how, in the manifestations of different forms of agency, the identities of residents operating in the complex working of power relations of the home can be traced. In exploring the understandings and workings of agency there are many common features observed in the three homes, though there naturally remain specific differences. These common points will be the central theme of discussion in this chapter.

According to Goffman (1959: 21), the manifestation of self is a social product in two ways: firstly, it is a product of the roles and performances that an individual plays in social situations; and secondly, it is a product of the validation and norms of society. Within an institution, the capacity to sustain this self of a resident depends on his/her capacity to make one's own decision, forcing the resident into attempting the construction of the self under abnormal constraints (Branaman, 1997; 1iv). The expression of this capacity through the exercise of decision making can take subtle forms such as 'bargaining and negotiation, deception and manipulation, subversion and resistance as well as more intangible, cognitive processes of reflection and analysis' (Kabeer, 1999: 438). These can be seen as avenues through which dominated individuals subtly bargain to protect their self-identity with a set of institutional constraints and structures. Goffman (1961: 320) has also made reference to "selfhood residing in the cracks of the solid building of the world" where he suggests that certain resistant stances are available. I now turn to those illustrations from the three care homes, to demonstrate the complex interplay between the three constructs: power *(xoktti)*, agency (*virodh)*, and identity (osmitay).

8.3. Muted voices in confrontation

Silent resistance (Vogo *virodh)* were a common everyday 'weapon' used by the residents to confront the power *(xoktti)* exercised by the staff and management in the homes (Scott, 1985). It only marginally, if at all, managed to affect the various forms of controls (*formai)*. However, from the residents' point of view, it can be seen as a far more effective weapon than loud defiance as they had learnt from their experiences in the past, when a vocal protest against the restrictions imposed by the staff was followed by further subjection to even more restrictions. The feeling of seeing the staff helpless, even if momentarily, gave the residents a sense of personal gratification. This was seen as an attempt to diminish the institutional identity and reclaim one's own identity (*osmitay)* – even if it was done secretly.

Residents gave two explanations for *Vogo virodh (*silent resistance*)* against the authority of the institution: firstly, some found it inconceivable to protest vocally against the institutional powers of authority, their commands and orders, and secondly, residents did not see the merit of vocal protest against the authority of the homes (their past experiences contributed to this feeling). Raja from the Government home remarked:

> *"The staff here is very powerful, you cannot say anything to them. They will be all over the place and may even give you a smack. So you have to be careful when you are not happy with things here. I prefer to show that I ignore them but I do not" (Raja, Resident, Government home)*

Similarly Violet from the Religious home described her interaction

> *"In the beginning I was very active and used to speak out when I felt something was wrong but they kept telling me off. Three years back they said that I am becoming too active and if it continues they would not keep me here then. They said, 'these days of mine are not to roam or get too excited. I need to sit and repent for all the bad things I have done in life'. From then I just keep to myself…" (Violet, Resident, Religious home)*

These accounts represent the two reasons I mentioned which formed a pattern in many other interviews with residents. Peppered in my data were two forms of silent protest that came as a result of these patterns – visible and invisible. The first form attempts (not always successfully) to visibly convey resistance to impositions

meted out to them. Though Violet in the above account claimed to remain quiet, her further account on her present dealings in the Religious home painted an interesting picture:

> *"If the Manager tells me something, I pretend I cannot hear. She keeps screaming but I continue pretending. She gets fed up and leaves." (Violet, Resident, Religious home)*

Similarly Sunil in the Private home claims:

> *"I do not like the Manager; she used to publicly humiliate me so many times. I have stopped talking to her now. Every month I go and give her 3000 rupees (monthly fee) and that's it. She gives me a receipt. I do not even greet her in the hallway or anywhere else we may meet. I just treat her as being non-existent. I am sure she does not like it; she has tried to make a conversation but I just pass and appear to be in deep thought. Now she does not talk as well, but she talks about me to others and makes faces." (Sunil, Resident, Private home)*

Similarly, in the Religious home, the feeling of insecurity and being told time and again by staff and management *'if you do not behave you will be sent home'* led Reggie to a visible form of silent protest.

> *An instance of this was reflected when a religious group came to visit the home and organise some games for the residents. The manager had instructed everyone to be dressed in their Sunday best. A bell was rung for the residents to gather in the living room. The religious group arrived and was introducing themselves and just about to begin a game with the residents. Just then Reggie was seen entering the living room in shorts and instantly joined the game. The manager was furious and after the religious group left, reprimanded Reggie who did not justify his presence but was silently smiling all the time... (Field notes, August 2011, Religious home)*

Leena added further to these forms of visible muted protest in her account below:

> *"In the last two years I have stopped greeting them (Manager and Assistant Manager), I do not even say good morning. I also remain very quiet in the home. However, when I am out, particularly in the Church, I enjoy myself….take active part in religious activities. In the house I do not do anything; I just keep away and do not talk. They also do not talk. They are telling the other residents that 'Leena is greeting everyone in the village, while coming from mass but she does*

> *not greet us'. They also say that 'they do not see the same spirit in me in the home'. I do not have the mood to do anything here, for I have done loads for them, but they have no appreciation, so I do not want to continue. My conscience feels guilty sometimes, but I just cannot be the same in the home anymore and it will stay this way." (Leena, Resident, Religious home)*

These visible narratives of silent resistance (*Vogo virodh)* follow the pattern of many others I have heard of residents showing their rejection of unacceptable systems in the home. Conscious decisions by residents to avoid conversation with the staff and management, or public rejection of management orders were instances that could not be seen as achieving a specific outcome. It was, however, acquiring the ability to make this choice (*iccha)* which was denied in the past that gave the resident a feeling of empowerment and self-worth (Kabeer 1999), the implication being that the residents exercised their choice (*iccha)* in their own decision making which was possible because of the muted voice he/she chose to take.

Analysis of my interviews with the residents and my daily accounts in the homes revealed invisible forms of *Vogo virodh*. This form implied subjecting themselves to the rules and regulations of the institution. This would mean obliging all demands and just going with the flow of what the institution demands. This attempt, according to Goffman (1961) (and as we have analysed in the previous chapter) makes the individual lose himself/herself completely and become more mechanical than human. The resident is seen to be subjecting him/herself to the rules and regulations of the institution. The way in which some residents were seen responding to prayer times, meal times, and bedtimes was representative of this theme. However, if taking Goffman's line of analysis, this theme implies the success of the institutionalisation process. Yet, my interactions with residents demonstrated a deeper implication. Residents claimed to align with the rules and regulations (*nem ani kaide)* consciously – not because they had begun accepting them but as a strategy 'to get into their good books' with the staff and management so as to be able to earn small amounts of autonomy (*aplo adhikar)* from the system.

> *"I just do what I am told to, I do not agree with them but I do it so that I am in their good books. And if that happens, they will not be targeting me and instead they serve bigger*

> *portions of dinner and even take me out with them" (Fatima, Resident, Religious home)*

The account about Milena from the Government home mentioned in the last chapter (see page 189) can be seen in line with this:

> *After being reprimanded and taunted by the staff for talking to a male (which was a taboo in the home) Milena withdrew and went to sleep after this. She kept her social interactions to a minimum the following day. This was aggravated when she was nicknamed 'Biazuan' meaning a woman with a loose character for her action of talking to a male resident. This was followed by Milena apologising to the staff and acting according to their instructions. When I spoke to her about this, she said 'If you want to be happy in hell, you have to make friend with the devil'. (Fieldnotes, Government home, August, 2011)*

Thus, the residents as seen in the accounts above make friends with the staff and management not only to ensure privileges but, more importantly, as a strategy to work the framework of power *(xoktti)* to their least disadvantage.

Vogo virodh also included covert forms like theft, urination, and delaying jobs as evident from my interaction with the residents. The female staff toilet in the Government home was located close to the female dormitory. On at least four occasions during my field work, different staff found themselves locked in the toilets because a resident locked them in. In fact, the practice just before I left the home was to keep a staff colleague standing outside to avoid being locked in. Theft was another form of *Vogo virodh*.

> *"Savita (staff) said she had left her watch on the sink platform while she was cleaning the toilets in one of the dormitories. When she finished cleaning she could not find the watch. I was present in the dormitory at that time and only residents had come in and out of the toilet area during that period of 15 mins. She began searching for her watch. It was not found. All the lockers of residents in the dormitory were searched by the staff but the watch was not found. Two days later the watch was found outside the staff room: it had been smashed." (Field notes, September 2011, Government home)*

Similarly in the Private home, I was told by Suraj (staff) about a resident who stole books from the home's library. He used to steal them and give them to passers-by or children in the village when he went on walks. Everyone was anxious about

this disappearance of books; nobody suspected him, till one of the staff's extended relatives was offered a book. When the resident was asked about his intention, he said he did not have any, he just did it. A closer look at this account and that of 'Savita's missing watch' manifest a critique of their subordinated selves. Deviance is therefore seen as in this case a manifestation of one's agency *(virodh)* and ultimately identity (*osmitay)*.

> *"One of the residents, everyone says it was Laxmi but I am not sure, poured coconut oil on the staff stairs. When Kareena and I finished our shift we were rushing down those stairs to catch the bus. Kareena ran ahead. Just then I noticed something on the floor and told her 'be careful, there is water on the floor'. On examination, we found that it was oil. So we were careful and climbed through it very slowly. We walked very slowly and also cautioned the other staff. Nobody found out who did it to date, but I am sure it is the ladies." (Savita, staff, Government home)*

The invisible form of mute strategies point to an interesting avenue through which residents subtly bargain to negate institutional identity within the constraints of a controlled environment. As emphasised earlier, in some instances they were strategies of survival and, in others stratagems of resistance.

8.4. Agency as resisting power

The forms of agency *(virodh)* identified so far could be associated with invisible forms of resistance whereby without entering into any direct confrontation with the institution, the residents used almost imperceptible strategies to work the framework of power in the institutions to their least disadvantage, if not any advantage. But, as will be seen in the illustrations below, not all acts of resistance were covert, and the residents on some occasions would get into a confrontation with the management and staff when their interests clashed. These confrontations could be on fundamental issues like respect, self-esteem, and injustice. These manifestations were more direct, where brawls and direct vocal resistance (*tondar virodh)* were characteristic.

> *"Around two months back, one of the staff, Tarani, stopped me from watching television. I got very angry and argued with her but she shouted back and asked me to return to my dormitory. I felt very humiliated, so, I went straight to the*

manager and reported the matter. The manager was new, and I am sure she did not want to get in trouble with the staff, so, she pacified me and said she will sort the matter the next day. However, the same situation continued for the next couple of days; the manager kept putting the matter off. I kept quiet too, and let the matter cool down as I needed permission to go out. So, on Tarani's off day, I asked the manager for permission to go out. They usually do not give permission on the same day but the manager gave me the permission. I visited the Provedoria head office and complained to the Assistant Director. She used to know my family, so she was very good to me. She, right in front of me issued a written notice to the manager asking her that the residents be allowed television between 17.00 and 18.00 daily. The news had already reached the home before my return. When I returned back, the manager began scolding me for taking matters to the head office. I told the manager that I would not have taken the matters up if she had acted on time. I also told her, 'I did not report the matter about your involvement but if you try to harass me, I would go and report the matter.' The manager kept quiet. Tarani on the next day reprimanded me, but I did not keep quiet. I gave back and told her not to interfere with me; otherwise, I will complain again. She has stopped talking to me and does not even respond if I ask her some medical question. If she says something it is only 'ask the Assistant Director'. She has told other residents to stop talking to me too. Most of them have begun to listen to her, and they are foolish. They do not come to watch the television either; in fact, it is only Theresa, my friend and me, who watch the television during that time. Tarani is trying to isolate me. Imagine, I fought for these people's right but they do not even value it. Anyway, what do I have to lose? I have got my voice (tallo) heard. I have let them (staff) know that they cannot boss around me. I am educated and aware of my rights and I am not going to allow them to demean me. That is what they try to do every time…." (Carmen, Resident, Government home)

Carmen's account demonstrates her anger and humiliation at the restrictions placed on her autonomy. She, however, attempts to exercise her individual identity by not allowing herself to be *'bossed around'*. Her attempt at securing her identity (*osmitay)* and rights (*hok*) against that of the institution was apparent from her manifestation of defiance of the system. This also shows that the defiance exercised by Carmen used the repertoires of influence politics available to her. However, this act introduced Carmen to newer forms of subjection –*'being isolated'* and thus

demonstrates the multiple power dynamics at play in the care home – since she missed being caught at the first level she was caught at the second. The case of Lawry from the Private home can be seen as forming a pattern with Carmen's account:

> *On my first day at the Private home, Lawry was involved in a serious discussion about the political system in Goa with Sunil in the dining area. This discussion had continued from the common space. When they reached the dining area, Lawry sat on the seat next to Sunil's which belonged to Dessai. When the staff saw this they began admonishing Lawry, 'This is not your home that you sit where you wish; here you need to follow rules and regulation'. To which Lawry replied, 'You are a shudra (a low caste) and you are telling me! Your salary comes from the money I pay, so you better keep quiet and do your job.' The manager intervened just then and asked the staff to start serving lunch. Lawry kept shouting about how offended he was, hence the manager pacified him and told him she would speak to the staff but got him to go back to his seat. After the incident she went to the staff and said 'if you need to control* (*formai*) *them, you need to appease them' (Field notes, October, Private home).*

From *Lawry's* point of view, his expression was an attempt to resist the authoritarian system. Vocal proclamation of the high caste he belonged to is seen as an attempt to sabotage the staff. However, it is clear that the manager did not agree with his vocal resistance (*tondar virodh)* but her response was different from the staff in Carmen's case; instead she used manipulation as her pacifying strategy. Thus pacifying and appeasing tactics were used as strategies of subjection by the management and staff to curb the resident's vocal expressions of resistance. This provides a platform for understanding important dynamics of resistance and power in care homes.

Open confrontations were also evidenced for more mundane everyday issues.

> *"I like to give tit for tat. I pay my money and stay here, so no one tries to play truant with me. If I see any loophole and do not see things fixed, I begin to fight. The residents nickname me as 'problem maker', but if I do not fight then they will only suffer. For example, we were in darkness last evening, something with our fuse, I think. They served our meal at 6.00 pm and told us to go to bed at 7.00 pm, imagine! I cannot do that, I get constipation and at the same time I feel hungry at night if I eat so early. So I told Sister I cannot do it.*

She said "you cannot tolerate for one day?" To which I immediately replied, 'will you go to sleep at the same time?' I told her to give a battery lamp in my room and then I will leave, but she refused. So I sat in the living room, I did not move. After some time, she got a lamp and gave me and I went to my room." (Felix, Resident, Religious home)

We were taking the residents for an outing; we took them in batches. Last time we had taken some so this time we needed to take different individuals. Laxmi did not go last time but her friend Srijani went, so we invited Laxmi. She said she will not go as Srijani is not going. So we asked Alice instead. On the day everyone was ready to go, Laxmi came and told us that she wants to come too. I said no, as we have already told Alice to come. She cursed me and said, 'God will see to you, hope you do not reach this place again…' (Savita, Staff, Government home)

As seen from the above illustrations, such actions were not entirely without risk, as there might be cases where residents like Carmen too frequently tried these tactics and then might get into trouble with the staff. However, in most cases these forms of confrontational vocal resistance (*tondar virodh)* were infrequent and in a way it is this infrequency that gave the strategies their strength. This suggests two things: firstly, since the flare-ups are infrequent, they remain unexpected and hence the staff members are seen to be less equipped to deal with them. Secondly, the management too do not see it as a threat because of its infrequent nature and hence in many cases the residents are able to achieve their immediate objective. However, in some cases, the management may resort to newer forms of subjection.

8.5. Resistance as diagnosing power

The residents enacted daily different forms of minor deviances of the restrictions enforced on them by the home. Through these myriad forms of covert resistance (*gutt virodh)* the residents attempted to resist institutional identities. Many of these deviances included secrets and silence through which residents often colluded to hide knowledge from the staff and management. Residents also covered up for each other in minor matters such as taking a daily bath which was not allowed in the Government home, sneaking in cigarettes and alcohol which was restricted in the Private home, or secretly keeping a mobile phone and sneaking in food from outside in the Religious home. These deviances indicate the power *(xoktti)* that is

exercised on the residents through a range of prohibitions and restrictions and which they both embrace and resist (Abu-Lughod, 1990).

It was not surprising then, given their non-conformity, that these residents were more likely to recognise the effects of institutionalisation and the resultant eventual loss of self. Because of this, they were also most likely to recall arguments with the staff as they challenged the discretionary use of *xoktti*.

> *"They (staff and management) constantly instruct us to clean up our rooms, make our beds, wear this or that, and all those many things. It gets to me and I say I am old enough to be your mother and teach you these things…you're not my mother…you can talk to me better than that because not only am I a grown up like you but I am also older than you…she went mad and told me I am back chatting and would be out if I repeat things like that…I do not care and I know they will not throw me out as they need the money which comes from my charges…..and I do not exactly care about being in their bad books…If I had the chance I would complain…I think we should be able to complain to someone if the staff is not doing something right as they never listen to you" (Fatima, Resident, Religious home)*

Though this argument is seen as covert resistance (*gutt virodh),* the sentiments express discretionary use of power by the staff to suppress vocal resistance from resistance on the one hand, and on the other absence of a grievance redressal system in place within the homes.

There were also instances of outright defiance and these affected the staff. The four accounts below illustrate this:

> *"Some of the residents do certain things when they are angry, things that you cannot tolerate. I will give you a small example: when I go to serve the residents soup in their dormitories, there are always some who want to trouble us. They take the soup in their cup, taste it and make a disgusting sound, and pour it in the bin bucket in front of us. Once in a way you can understand, but some residents do it too often. It is us who cook it; now imagine how hurting it is, would we not get upset? If we avoid serving her, thinking she will do it again, she blames us and in fact goes to the manager and complains. The Manager then questions us. When we try to justify, she tells us to let her do anything, even throw out, and do your duty of serving her." (Kareena, Staff, Government home)*

"On two occasions Sumitra (staff nurse) gave me the wrong tablets in the evening. The next morning, I went and complained to the manager. She tried to pacify me and said 'everyone makes mistakes'. So I let it go and decided if she does it again, I will take further action; imagine she kills me like this. The next time when she came on duty, she began ordering me around. She is telling me 'hey, do not go outside, stay in the hallway next to your dormitory.' I said, 'No, I am not listening to you and you do not tell me, if you do, I will take those tablets I have kept and give to the director and show them to all the newspapers. It can cost you your job. So you please try not to interfere with me; you can play games with others, but not me.' Now she does not interfere. She cannot do anything to me for I am the resident; I can throw a stone at her if I want; she will have to understand but she cannot. I will keep my Dirent (right)." (Lactacio, Resident, Government home)

They check our lockers; they say they want to see if they are clean. Then they start throwing my things away saying they are dirty, old etc. I want them and that's why I have kept them, but they do not understand. There are these itching leaves in the backyard leading to the forest. I got them and put them in my drawer. They did not come to check our drawers for two days but came on the third day. I had scattered them everywhere in the drawer, she (the staff) wondered what leaves they are and inspected them. She started thinking I had those for smoking 'bidhi' (local cigarettes) or something; she even smelt them. Oh! In a few minutes her finger and nose started itching. She started screaming, I pretended to be sympathetic and told her that I was not aware, but deep down I was happy that I taught her a lesson." (Laxmi, Resident, Government home)

Fatima refused to cut vegetables so the staff scolded her and said, 'you only want to eat free'. Fatima did not say anything back, but she messed herself and the place she sat. The staff had to help her to the bathroom, help her clean up and also clean the dining area. A staff remarked, 'You are doing this to trouble us; I know you did this on purpose.' (Field notes, August 2011, Religious home)

These four instances speak of different forms of outright deviance targeted against the staff. They did not promise to achieve anything in terms of the actual issues – the controls the residents were subjected to. In fact in many cases like in that of Lactacio, the outcome was thought to be negative. A focus on the outcome,

however, may deter us from appreciating the significance of the defiance. As we can see from all the four instances above, there was no intention to redress a grievance in such a way that it does not recur again. These accounts demonstrated ways of getting back at the staff. The varieties of suffering by the staff, and their helplessness at reacting enabled the residents to carve out a personal agency as against the power exercised by the staff. The account given by Lactacio spoke of a direct negotiation between the staff and the resident. However, there were also instances where resistance was not so much an outright defiance of the system as a subtle negotiation and, in some cases, manipulation.

> *"They give us vegetables to cut or rice to clean wash? I do not like doing that. Why should I do it, it is their job. They give us this work and sit down and gossip. I take the knife and begin wobbling with it, implying I am unable to do it. They take the knife away from me and say 'leave it, you do not do it. " (Alice, Resident, Government home)*

> *"They do not allow us to watch television after 9.00 pm. In fact the living room is said to be out of bound. We asked whether we could sit in the dining area to which she agreed. Now, we have begun playing cards here and we also make fun of them here. I prefer this to watching television. " (Leena, Resident, Religious home)*

> *"Suraj (staff) helps sneak liquor into the home; he also buys cigarettes for me. I give him some 'chai pani' (money). He does it for many other people too." (Rajan, Resident, Private home)*

These accounts illustrate the high degree of stealth or manipulation involved in many everyday actions of the residents which go on to form *gutt virodh*. For example, Alice did not directly oppose the staff about her dislike for the job. Rather, she took refuge in accepted social codes, such as health problems, to demonstrate her unsuitability for the job. Rajan manipulated the staff by using money to get his way around. Through these acts, the resident is able to carry out her/his own wishes through a process of manipulating social codes – immoral or illegal – rather than open confrontation.

8.6. Mediators as agents of resistance

Residents also felt that it was difficult to voice their resistance directly to the management or the staff. Hence instances of residents using mediators (*madesti)* like visitors, animals, plants, and God were common.

> *"I was very weak so they used to get my meals on top to my bed. In two or three days the staff started grumbling (gozal), saying she can eat well but cannot come down and take her own food. I did not know about it, from a distance I saw the resident who was getting food for me coming with my empty plate back. I asked her what happened; she told me the discussion down and said that the staff has said if I want to eat I should come down with my plate. I took the plate, went near God's statue and cried and told God, 'See they have sent my empty plate back, they could have at least given the food today and said that I could take the food from downstairs tomorrow' I said this very loud so that they could hear. I prayed to God to give me some strength to walk up and down the stairs with my plate. So I walked down the stairs very slowly. When I reached there all started saying 'Wow good Laxmi has come very good'. I only said one thing 'God is watching you' and kept quiet" (Laxmi, Resident, Government home)*

> *Gopi was seen cursing staff, complaining about fellow residents, or simply moaning while counting religious beads. She did this in her room but also in public spaces, including the living room which the staff accessed frequently. (Field notes, October 2011, Private home)*

The implication in the above accounts was that the residents wanted their thoughts to reach the staff. They found confrontation or direct or vocal resistance (*tondar virodh)* very difficult. They believed that their moaning while counting their beads and their loud prayers to God not only helped vent the anger they experienced but also provided them with an opportunity to indirectly resist the structures they felt tied into.

> *Maria was in the garden, she was talking to the plants. She kept saying 'you are all free, look at me, I am so restricted….what has this place done to me'. (Field notes, August 2011, Religious home)*

Similarly, Fatima from the Religious home made friends with pets and spoke to pets about her frustrations.

> *Fatima had two cats. During my initial data collection days one of her cats went missing. Fatima was very disturbed about this. She did not talk to anyone the whole day; she did not take her meals. I saw her sitting with the other cat and when a staff passed by she loudly remarked "You know, Meow (the cat's name), one of these people has taken your brother. God will punish them and burn them in hell" (Fieldnotes, August 2011, Religious home).*

Again this blatant account did not do anything to achieve any outcome but the resident's agency at voicing her fears spoken loud. In other instances, families, visitors, and doctors were used to convey messages of resistance to the staff and management:

> *"The food was too spicy for me, it was not agreeing with me, so Sr. Rose the previous manager said, 'we will give you boiled food'. The present manager who came in last year wanted me to eat this food. She said that I was fit to eat everything. I told her I was not feeling well after I ate the normal food, so she took me to the Doctor the next day. I told the Doctor my concern and he agreed with me. He told the Sister to give me boiled food as I have problems with digesting. She did not believe me; she only wanted to create problems for me. (Leena, Resident, Religious home)*

> *"You have to be careful when dealing with these people. If there is even a small mistake, they tell their families, who then complain to the management." (Shyam, Staff, Private home)*

Visits by individuals or groups (religious or charity) were seen as mechanisms for redressing grievances. Accounts from the residents followed a pattern – sharing their problems and difficulties of institutional life. This manifestation saw the resident questioning the very basic structure and foundations of institutional living. This questioning provided them with an opportunity to create a niche to express their own resisting voices which were otherwise restricted.

8.7. Critics in resistance

The above sub-sections demonstrated everyday practical acts of resistance – visible and/or invisible. There was another category of resistance which had no direct relationship to the resident's interest, protection of their rights, or manipulation of the

system to their least disadvantage. These acts of resistance were intended to display a critique of the institutional care system. It provided a forum for a counter-narrative within the dominant institutionalisation order. Like the previous acts, here too the intention was not of changing the system but was limited to being a critique of the current system (*Khodi kadun virodh korop)*. This criticising took place in groups or at individual levels.

Residents aptly articulated the contradictory nature of the home and in some cases placed their criticisms within a larger social context. For example, Laxmi in the Government home compared the system of the home to that of a prison:

> *"We are in chains (Amkam bedi galea)…I think this place is far from home…. It is like a prison! They lock you up all the time." (Laxmi, Resident, Government home)*

These expressions were often used in interactions with their peers or with visitors in the home. However, these expressions were also used as indirect taunts to staff and management to suggest that they were worthy of better treatment than what they were getting. Moreover, these taunts were not only used in the residents' rooms but also in public spaces such as living and dining rooms. They clearly demonstrate the residents' objections to the existing structures with all their power and domination. For example, in the living room of the Religious home, Felix was talking to Matthew about the manager:

> *"Because you are the manager, I have to salute you, but for what reason…I have to listen to your instructions and dictates. Why? For what reason? Is this Hitler* raj (rule)? *" (Field notes, August 2011, Religious home)*

Similarly,

> *When the manager was on her roll call rounds, she was walking in the hallway. When Rukmini told other residents in a loud voice: 'Madam is here to see whether we are dead or alive. We should all lie on our beds and appear dead, so that she does not count from the door but comes to our beds.' All of them laughed. (Field notes, August 2011, Government home)*

This was a vocal critique by the residents of the practices in the home. It was also an indication of encouraging resistance in other residents. This and other taunts were extended to acting out roles and name calling in the homes as well.

> *"When the dormitory is locked, Alice acts like the manager. She is really very good in acting the manager. She talks and walks just like her. Sometimes she also imitates the staff. She keeps ordering us around like the staff do and swears at us like they do. We all laugh then." (Laxmi, Resident, Government home)*

> *"We used to call her Hitler. Now she knows it, but before she was not aware of it. We used to use this name in front of her. She often asks us: 'who is Hitler?' and we used to give her different answers. Eventually she found out. Now we call her 'Meow', which is the name of our cat here. She will never find out. Even when she is around we talk to the cat and address her as 'Meow' which for us means the manager. We say, 'Meow Modh marla..amkam kiteak sotaita' (Cat, are you possessed, why are you making us suffer), or 'Mosti ailolo' (cat, why are you acting too smart). We laugh and the manager laughs with us not knowing we say these things to her (Fatima, Resident, Religious home).*

In a similar way, Sunil accounted to me how he and his roommate poked fun at the Manager of the Private home:

> *"She cannot speak Konkani well…She tries to tell us things in Konkani; we do not say anything in front of her but when we are on our own we talk about it and laugh. I imitate her accent too, it is really funny." Sunil imitates it to me too during the interview. "We hate her, she is very bad, no sensitivity to our needs. She only favours residents who have money…selfish lady" (Sunil, Resident, Private home).*

The staff were also criticised by the residents based on their behaviours. For instance, Gabriel was criticised for stealing food from the home and taking it home; Kareena was repeatedly complained about for her dominating and violent behaviour towards residents; and Raju was taunted for his poor knowledge of Konkani.

The logic behind this was to criticise someone or something they otherwise had no way of doing. These acts did not appear to have any intention of securing advantages or challenging domination. They were used against both the staff and the management but, most importantly, to represent the existing system in the homes. I was easily tempted to assume the total ineffectiveness of these acts but a closer look revealed a different perspective. In this regard, the question was whether these attempts really worked as a critique or were they merely a pressure valve? These acts had a four dimensional significance. Firstly, they served as a momentary inversion

into the institutional structures through focusing on the weakness of the different figures of management. Secondly, these acts seemed to cross the non-breachable boundaries between them and the management. Thirdly, in many instances these nicknames, role playing and abuses reached the management or staff and thus communicated to them what the residents' perceptions about them were. Finally, the critique was seen as recognising one's identity as superior to that of the staff and management and also as I already pointed out earlier, acting as a safety-valve for their frustrations and other negative emotions, perhaps even in a subconscious way of making staff feel what they were feeling (i.e. I feel worthless, so I make you feel the same).

Besides the above-mentioned everyday individual and group acts, criticisms also took place on fundamental issues where some of the values unquestioned for decades were gradually being challenged.

> *"On the International Day for the Old, a number of us were invited for a public event held by HelpAge India. There I was invited to speak. Now what will I speak about at this public gathering? I thought this was a chance to raise my voice against the baddies. So I said, 'I am staying at a home and on my entry I had to give an affidavit in the beginning, that is, naming who would take me in case of a health problem. I have chosen to go into the home because I do not have anyone. But I am afraid of illness as I may be asked to leave.' I continued, 'I am happy in the home as you get everything on a plate but I feel bad when people look at the home as a place to dump excess food. The left overs are brought in and we are asked to say thank you to the donors. Residents pay monthly fees so why do they have to feel that they are relying on daan (charity). The main thing they need to take care of us is AHAAR AND AZAAR (food and health) and that's all; but both are neglected. How will they cater for our emotional and social needs? 'PAAD PADU SOZPACHE NA (Curse them, I cannot bear this)." (Rajan, Resident, Private home)*

This account is of taking the criticism to a public forum. It criticises and questions the edicts of the system and implicitly challenges the authority of those who represent and benefit from it. It was a more direct form of criticism. Furthermore, Rajan found it easier to criticise the extant system at the public forum

where he referred to it in general as problems of the care home systems, and to directly express his opinion on these issues in front of others.

8.8. Conclusion

I have, in this chapter, provided a deeper understanding of agency *(virodh)* among the residents, who are constrained by their limited access to institutional power (*xokti)* and control (*formai)*. I have demonstrated the myriad forms of agency – *vogo virodh (*silent resistance*), tondar virodh (*vocal resistance), *gutt virodh (*covert resistance*), madesti virodhak vapurap* (using mediators as agents of resistance*)* and *Khodi kadun virodh korop* (resisting by critiquing) as expressed by the residents. My discussion throughout was built on two pillars – agency as a manifestation of identity and agency as a form of resistance. Accounts from the residents were explored through them. Moreover, agency as a manifestation of identity implied resistance to the institutional structures of power within which the residents were located. At the same time, agency as a form of resistance can include a manifestation of identity.

Many reactions of the residents spoken of above, in terms of the overt reactions of rebellious attitude like the brawls, often appear to subvert the purposes of the institution. The repercussions sometimes can be risky, including isolation, ill-treatment, being deprived of services or being asked to leave. However some residents challenge these repercussions and take the matter still further higher up. Others withdraw to their own selves and their imaginary personal spaces. Many residents are seen to challenge the situation by refusing to cooperate and refusing to accept the values and roles assigned to them by the institution i.e. of a passive old person. Finally, there are residents who resort to a mechanical following of rules and regulation for fear of repercussion. Despite this varied nature, the aim of the subtle and mundane nature of the acts was resisting only to secure one's least disadvantage, i.e. it did not aim to change the authoritative systems in place but rather aimed to secure the least possible advantages or disadvantage within the framework of power and control.

The findings point to the scope of agency by moving beyond the binary of resistance and subordination to explore how people use various aspects of their subordination to renegotiate their position within the power structure. Thus, by

attempting to re-conceive agency outside emancipatory terms I was able to see how the structures of subordination – enforced activities, weakening health, and restricted space – served as means for the residents to achieve their own ends, however limited these might be. The limited impact questions the transformative potential of the agency within the hyphens of power (Abu-Lughod, 1990). This question proves helpful in forcing one to think of potential for long term changes in the institutional care system.

> *"My family has deserted me…this place is like a prison…what else do I have to lose.....so I keep telling them off and arguing with them for my rights…Now, either I will be transferred to another home or I will die in the next few years… … I have told them that as well, but I have also said that before I go 'Dekh dakhoun vetolo mhunn' (I will teach you all a lesson and go)."(Lactacio, Resident, Government home)*

The account by Lactacio attempts to answer the question by referring to what Kabeer (2005) calls transformative agencies. The implication is that, while Lactacio may get his immediate needs met through his expressions of everyday resistance, more importantly, as he claims, his expressions will provide a challenge to the existing system and thus he does his best to prevent it from getting reproduced in the future. However, my analysis views the question of long term potential of agency as having the potential to disregard the minute and constrained expressions that occur within a restricted context. I argue that it is only by placing these acts within their context that we can appreciate their significance in carving out spaces of resistance and autonomy for the residents in question to subvert the purposes of the institution.

From the researcher's point of view, the stratagems discussed above are constituted as expressions of resistance. However, for the residents they are everyday forms of existence and struggles. Besides getting further admonishments from the staff, individual stratagems may invite mutual distrust among residents themselves – an example is that residents must beware lest another resident reports his/her covert resistance in the hope of gaining favours from the staff. The implication is that agency reflects a strategy of individual survival for the residents in the homes.

However, by adopting a viewpoint which neither unnecessarily romanticises the struggles of the residents nor falls prey to arguments about residents as passive

victims, I have uncovered and understood better the residents' stories of preserving their individual identity through their agency within the surrounding framework of power. These everyday struggles for existence within the care home are perceived by residents and staff as ending with departure from the home. Departures, in their varied forms, will be the central point of discussion in the next chapter.

Chapter 9: "I await my final journey": Residents' perception of departure from care homes

9.1. Introduction

> *It was my second day in the Government home…Milena (resident) asked me where I would be the next year and I told her that I would be back at the University in Edinburgh…I then inquired, 'What about you?' to which she replied, 'I am counting my days here. Next year I may be gone altogether, just like Mary who was here last month and see, this month she is gone'…. (Field notes, Government home, August 2011)*

Milena's awareness of her impermanence in the home provoked me to look further into how residents perceived their departure (*bhairsarap)* from the care homes. Thus, initially I simply began asking residents the same question that Milena posed to me 'What would you be doing next year'. The responses included: '*dead, I hope'*; '*I don't want to be a burden on others*' and '*I hope to be no longer around*'. In an emotive area like this, residents saw life as a burden and therefore did envisage death as a release – thus claiming freedom *(sutka).* Leena's and Shradha's accounts cited below portray other forms of departures, depicting insecurity (*suroksha na*) and fear (*birant).*

> *"….they have sent people home in the past, but they had a home. If they tell me to go out from here, I do not know where I will go." (Leena, Resident, Religious home)*

> *"If I feel ill and cannot walk to the dining area they (the staff and management) say: 'if you cannot manage, then you need to consider moving into the hospital'…. I know once in the hospital I know that will be end of life for me…I have seen what has happened to other residents" (Madhuri, Resident, Private home)*

Madhuri's, Leena's and Milena's perceptions were formed on the basis of how their fellow residents in the care home experienced departure and how the staff and management constructed departure in their interactions with these residents. This understanding posed a set of questions in my mind. What were residents' perceptions of different forms of departure from the care home? Did they see departure as a manifestation of freedom from institutional controls or an aftermath of the agency

they manifested as depicted in the previous chapter, or was departure something that they associated with fear and insecurity? How did the residents see themselves preparing for departure? What was the role of staff and management in the departure of residents and their preparation for this departure?

In order to find answers to these questions, this chapter will explore three forms of departures (*bhairsarap)* which residents in care homes in Goa anticipated: leaving the care home as a result of transfer (*suvat badalpak),* expulsion or choice; hospitalisation (*aspitrin vochop)* as a result of ill health, and; death (*mornon).* This understanding will be based on data gathered from participant observation and interviews with 24 residents across the three homes. Additionally, I also highlight the views of staff and management about how they help residents to prepare for the different forms of perceived departures. In so doing, I begin with a theoretical discussion on departures from care homes, and what it means to residents. I then discuss the three forms of departures as mentioned above. In conclusion, I show how these perceptions and preparations for departure are coping mechanisms used by residents and staff as extensions of their struggle for survival, dignity and control in the care home.

9.2. Departures from care homes

Righton (1970, in Clough 1981: 131) writes that "every resident in a residential unit will eventually leave – whether it is for his family, for another unit, for a hostel, for lodgings or other forms of relatively independent living, or for the grave". Researchers have studied the different forms of departures that end the residential careers of residents of care homes. Hospitalisation, death and moving to other accommodations are the commonest ways of leaving care homes (Clough, 1981; Davies and Duncan, 1975).

These accounts provide two important insights. Firstly, they help to document the trends in discharges from the care homes due to death (*moron),* hospitalisation (*aspitrin vochop)* and transfer (*suvat badalpak)* to other accommodation, and secondly, they help to explain the implications that these departures (*bhairsarap)* have on the remaining residents, particularly in relation to how they perceive their

own departure and the preparations which they undertake to enable it. It is the second insight that attracts my interest and forms the central focus of this chapter.

Miller and Gwynne (1972) argue that transfer (*suvat badalpak)* between residential care settings for older people is relatively rare. The majority of transfers are institutionally driven; very few instances of residents securing transfers for themselves are reported in studies. In institutionally-driven transfer, institutions use each other as a receptacle for trouble makers. Hospitalisation (*aspitrin vochop),* on the other hand, is seen as a more frequent form of departure from care homes. Davies and Duncan (1975), who studied discharges from residential homes for the elderly in Reading between 1970 and 1974, found that 37% of the residents left for hospitals. Clough (1981) in his study of departure from a care home found that a substantial proportion of residents, i.e. nine out of forty-two, entered hospital during an eleven month period. Of the nine, six went as short stay patients, the three who were moved permanently to the hospital died, and of the six short-stay patients only two returned to the home and they subsequently died. Thus, understandably, there is a general fear among residents in care homes about hospitalisation (Clough, 1981). Miller and Gwynne (1972) write of the centrality of death (*mornon)* in long-term residential care institutions. Similarly, the studies by Davies and Duncan (1975) referred to above reported that 50% of residents were discharged from care homes in the form of death. Clough (1981) argues that death and hospitalisation (which most often leads to death) are the commonest ways of leaving care homes, where on average between 25 to 33% are likely to die each year. Miller and Gwynne (1972) suggest that the acknowledgement of the frequency of death may be avoided by little grief being shown by staff and residents when a resident dies, and by transferring ailing residents to die elsewhere, off the premises.

Various studies have attempted to research the impact that departures have on remaining residents and on care practices. The above-mentioned forms of departures imply that the resident has no control over his or her leaving process: it is uncontrollable and is inevitably painful for the resident undergoing it. However, the remaining residents and the staff have even deeper problems, particularly in terms of coping with these departures. They experience pain, fear, anxiety and insecurity. Clough (1981) pointed out how the death of fellow residents made thinking of dying

harder for remaining residents who showed resentment and fear for their poor health and unhappy circumstances. He also illustrated how hospitalisation was associated with anxiety, insecurity and fear in residents and was seen as permanent and ending with death. Researchers have considered various mechanisms that are used by both residents and staff to cope with and anticipate these departures. Miller and Gywnne, for example, examine defence mechanisms used by staff and residents to avoid facing these realities. They include: scapegoating of residents by staff (staff believe that problems are located within an individual resident and if the individual leaves, the problems will go too); denial that death is a significant end (in fact death is seen as a beginning to life after that; religious beliefs of residents and staff endorse this further); denial that death may be the final stage (situations in which residents die on the premises is avoided: residents may be transferred to hospitals or back to families); pretence of death being an exception rather than the norm; and greater focus on the departure of staff rather than of residents (due to transfer or underperformance).

The above discussion provides a basic description of the different forms of departures (*bhairsarap)* from care homes – transfer (*suvat badalpak)*, hospitalisation (*aspitrin vochop)* and death (*mornon*) – and the impact it has on remaining residents and staff. As gathered from my interviews with management in the three care homes I studied, on an average 10% of the residents died each year, 20% were hospitalised – many of whom eventually died – and 5% were transferred to other institutions. Transfers between institutions were more common in the Government home and Private home than the Religious home. However, transfers between different dormitories and rooms within the home took place frequently in all three homes (in this chapter this is not further considered as a form of departure). During my field work, the following departures were reported by the managers: Government home:1 death (during scoping study), 1 hospitalisation (transferred to the hospital after I completed participant observation in the home and subsequently died in the hospital during my interview phase in the home) and 6 transfers (all within the home, transferred to fill in beds of dead residents or to minimise trouble in particular dormitories); Private home: 0 death, 3 hospitalisations (none of whom were transferred or returned to the home during my stay) and 4 transfers (all within the

home – 3 to a geriatrics ward that the home ran and 1 to another room); Religious home: 1 death (after my participant observation phase), 2 hospitalisations (none of whom were transferred or returned to the home during my stay) and 0 transfers. All departures by death and hospitalisation took place in my absence. Hence, it was difficult to capture first-hand accounts of departures due to death and hospitalisation. At the same time, it was ethically challenging both for the residents and myself to talk about the death of a particular resident. Hence, when discussing death, it was in relation to the resident's own perception rather than an actual experience (in the process, however, the resident revealed information about the departure of individual residents in the past). Thus, departure, in the case of my study, is not only important from the point of view of how residents perceive the different forms of departure but more importantly how they cope with these perceptions and the preparations which they undergo to help them to cope.

In analysing the perceived forms of departures (*bhairsarap)* within my fieldwork, themes of fear *(birant)* and insecurity (*suroksha na)* as well as freedom (*sutka)* and spirituality *(bhoktiponn)* emerge, with a striking similarity to the literature examined so far. Thus the following sections will use the above discussion as a framework to explore how different forms of departures are perceived and anticipated in the care homes. In order to get a sense of this, I will examine how the residents understood each of the three forms of departure vis-à-vis the preparation that they undertook for it. This will help to explore what meanings the residents assigned to the different forms of departures, and whether their perception, practice and discourse regarding them reinforce the controlling nature of the institution. For the purpose of analytical convenience, I have divided the discussion into three sections: Transfers to other care settings; Hospitalisation; and Death. Each of these sections will explore the specific form of departure within a theoretical framework and then draw out implications by using relevant data from fieldwork.

9.3. Transfer to other care settings

Care homes transfer (*suvat badalpak)* residents to other care setting for implicit and explicit reasons. Miller and Gwynne (1972) demonstrate in their study the implicit reasons for the transfer by residential institutions. They claim that residents are transferred as a strategy to avoid situations in which the resident dies on

the premises. Institutions use upper age limits, illness, high numbers of residents, and lack of staff as reasons to justify this transfer. They suggest that residents who show signs of physical or mental deterioration are rapidly transferred elsewhere. In such cases, the staff do not find it possible to tell the remaining residents the truth about what has happened. In Miller and Gwynne's study, fictional responses such as *'He has gone away on holiday'* were given as an explanation to remaining residents, who did not question the explanation. Their apparently complacent response may be because they dared not question the explanation, lest they face a similar situation. Scapegoating of the residents by staff and management can be seen as an explicit reason for the transfer. This may result from the staff's and management's belief that if X left, then the rest of the residents would be under control. X is seen as a trouble maker, colluding, depressed – in general a bad influence. Sometimes ways are found of actually getting rid of X – by transfers to another institution or the family being asked to take X home. This demonstration could be seen as an exercise of constraint which could have far-reaching effects on remaining residents, with withdrawal, fear and insecurity being common.

As gathered from my interviews with management, residents were transferred to other care settings very rarely. In the most convenient but exceptional cases, residents left the home following disagreement with staff or management or because they were finding it difficult to cope with the regimentation in the home. This occurred very rarely according to both the residents and the staff:

> *"We do not have any short stay residents. Most of who come here are there till they are hospitalised or die. We had only a few cases which I remember where the residents were taken back by their families or the residents left for other homes" (Karuna, Manager, Private home)*

> *'Agatha (Resident) had packed her bags and told me her son would be coming to pick her up. She told me she did not like the care home and wanted to go back with her son. Her son came to visit her and left. She then told me that her roommate was very lucky as her family took her back when she told them she did not like the place' (Field notes, Religious home, August 2011)*

Thus the residents on their own could not choose to leave or were discouraged from leaving. A request like that of Agatha came from residents who

had been manipulated by their families into staying in the care home. The Manager was not prepared to allow them to return to their own home without the family's consent and the residents were told this. The family on the other hand did not give their consent. Additionally, there no legal sanction in Goa against compulsory admission to the care homes, so the residents were persuaded to stay. The result was that they were always hoping to leave. As a consequence they rarely enjoyed their life and eventually became resigned and unhappy.

In the case of my fieldwork, transfer of residents by the institution followed from disagreements that residents had with the controls of the home. Residents were also transferred to other homes or asked to leave the home if they were being difficult in accepting staff and management control:

> *"I was initially admitted in X Government home which was basically in my village. The manager who was there was a big robber: she used to steal food, toiletries and other things meant for residents and take it home. I came to know about it through one of my dorm mates. One day she reprimanded me for something, so I told her, 'I know about all your underhand works so you better not trouble me'. She complained to the director that I am smuggling alcohol in the home through my visitors. One day they told me they are taking me to the hospital and transferred me to this place. If I had had even a little doubt that they are doing this I would have shouted all the way and hit the driver too." (Lactacio, Resident, Government home)*

Lactacio claimed that the manager saw him as a threat to her authority and hence she decided to transfer him discreetly. Similarly, in chapter 8 (see page 204 and 205) I recounted an incident mentioned by Suraj (staff) from the Government home, where a resident had stolen books from the Private home's library. This resident was asked to leave the home because of his deviant ways. He was seen as conflicting with the structure the home had set up. His justification *'I just did it'* for stealing the library books was not probed further, according to Suraj. Thus in this case the resident was not transferred to another care setting like Ignatius but was asked to leave the care home.

Residents who were dying or were terminally ill were transferred to other care settings, particularly hospitals. The implications were twofold: firstly, many older people who experienced rejection by their families and wider society by being

put into the home were faced with a further rejection in the later stages of their life because of their deteriorating health. This environment, according to Miller and Gwynne (1972), creates insecurity and fear in the minds of the remaining residents. Secondly, it can help the home to dilute the proportion of residents who leave by dying – thus giving the staff relief (*visov*) from dealing with nothing but deterioration, no matter what they do. This aspect of leaving due to physical deterioration will be further highlighted in the next section on hospitalisation (*aspitrin vochop).*

9.4. Hospitalisation

Castle and Mor (1996) define hospitalisation of residents as being discharged from a care home to an acute-care hospital for at least 24 hours. This includes emergency and non-emergency transfers but excludes transfers to other long-term residential institutions or domestic care. Various studies have evaluated the factors leading to hospitalisatio (e.g. Grabowski *et al.,* 2008; Travis *et al.,* 2001; Murtaugh and Freiman, 1995; Higgs *et al.,* 1992; Kayser-Jones *et al.,* 1989). They have identified factors such as lack of immediately available in-house support services (x-ray, laboratory, and pharmacy departments); nursing/ medical issues (an insufficient number of adequately trained nursing staff, transfer for the physician's convenience, pressure from nursing staff for transfer, and poor nurse-physician communication); and family pressure for transfer. Often many of these factors interacted dynamically to influence the decision-making process, rather than purely clinical reasons.

The limited data available on hospitalisation of residents highlight the negative aspects of hospitalisation – mortality and morbidity (Castle and Mor, 1996; Weissert and Scanlon, 1985). Studies describe the hospitalisation of care home residents as leading to further mental and physical deterioration (Grabowski *et al.,* 2008; Gabow *et al.,* 1985). Further, mortality rates associated with the hospitalisation of care home residents are higher than in any other care setting (Grabowski *et al.,* 2008; Gabow *et al.,* 1985; Goldstein *et al.,* 1984). Thus the implication that hospitalisation has for remaining residents – as depicted in the literature – is further physical constrains (being bedridden, morbidity and mortality) and a new environment to adapt to. Using this framework I now turn to the perceptions regarding hospitalisation within the three homes I studied.

Departure of residents to hospitals as gathered from staff and management reports was the result of deteriorating health in residents. For most residents in my study it was long term – most of the time there was no coming back. Understandably there was a general fear about hospitalisation which created anxiety in the minds of residents. Staff members were well aware of this. They cared for highly dependent residents within the home. However, when they became totally dependent or when there were several residents who needed maximum help, they would recommend hospitalisation.

> *Raymond (Resident) was finding it difficult to walk to the dining table for his meals. He avoided going out of his room too; he slept in his bed the whole day. I was having a chat with him and he was telling me about the pain in his legs. Just then a staff entered and asked him to come for lunch, to which he replied' I can't'. The staff said "Well, you cannot stay here unless you walk; we will have to move you to the hospital". He later told me that he will try to walk as he does not want to go to the hospital as he knows it will make him worse. He also told me: 'I do not mind dying, but prefer it here than as a patient in the hospital'. This was my last day in the home. When I went to say goodbye to the residents and staff before returning to the UK, I noticed that Raymond had been transferred to the hospital. (Field notes, Religious home, December, 2011)*

Residents perceived hospitals as dying places and tried their best to avoid them. An incident in the Private home reinforces this:

> *"Manju (Resident) had a fall when she was getting up from her bed to go to the bathroom in the night. She started crying for help. Her roommate woke up but refused to help as she was scared for herself (she was also weak and old). So the resident waited on the floor for one hour and then caught the bed and slowly tried to rise. She was able to in a few attempts and slept then and so did the roommate. I asked the roommate why she did not call the manager in the night (every cottage has a phone to make internal calls), to which she replied that she does not know how to use all these modern gadgets. She added: 'I have to take care of myself, too. What if something were to happen to me in the bargain? I would end up in that hospital section and would not even enjoy the little freedom which I do'. Manju started crying and said "they will now put me in the hospital section as I will not be able to go for meals to the refectory 5 times a day.*

> *That place will kill me; in this cottage I had my freedom, nobody interfered as such. I could perform my puja and things. It is a dormitory system there. They will not allow me all these things. They say that, that place makes you bedridden, they cut your hair and eventually you die. I do not mind dying but I do not want to be treated like a bedridden". As a matter of fact, she was admitted to the Private home's hospital the next day. When I went to see her, she refused to talk to me. She was of the opinion that I may have influenced the manager's decision which I did not do. (Field notes, Private home, October, 2011)*

The above accounts depict a fear of going into hospital care and being limited to the space of your bed in the dormitories of hospitals. This perception had a negative impact on the residents in both instances, even before their admission in the hospital. There were no preparations in place to aid this form of departure (of residents). Their transfers at times were used by the care homes to make the remaining residents feel grateful and relatively fortunate. This however can be seen as a diversion strategy used by the staff from the more demanding primary task of helping those whose illness is terminal but who will take much longer to die (Miller and Gwynne, 1972). This brings me to the last form of departure from the home – death (*moron).*

9.5. Death

In care homes, dying and death is a regular event (Field, 2000). Thus, the experiences of staff and residents within care homes largely deal with "physical deterioration and dying" (Hockey, 1990:107). According to Sidell *et al. (*1997) one sixth of the residents in care homes die each year. Liebig (2003) in her study of care homes in India reported that 77% of discharges were as a result of the death of residents. Yet, the meaning of this strong association for older people in residential settings is largely unexplored (Field, 2000; Clark and Seymour, 1999).

Studies have attempted to examine older peoples' attitudes towards dying and death in general (Costello, 2001; Seymour, 2001; Field, 2000; Williams, 1990). They have reported on the attitudes of older people towards death, suggesting a 'heterogeneity and complexity of attitudes' (Field, 2000:278). These can be clubbed together under positive and negative attitudes towards dying. Williams (1990:99), for example, identified a number of contradictory patterns in older people's attitudes

towards dying. In particular, there was incompatibility between “two broad ideals of dying well: going as quickly and unconsciously as possible; and going only after an affectionate reunion with kin”. Negative attitudes were associated with when dying was somehow ‘arrested’ (e.g. becoming a 'vegetable') and/or where the person became a 'burden to others’. Young and Cullen (1996:182) additionally suggest that the loss of social relationships through the death of others, especially of those closest to them, meant that the older people “had less to live for and less to lose, and, in a way, most to gain from death”.

Studies have also explored different ways in which older people cope with anxieties about and acceptance of death. Various factors have been pointed out in understanding the coping mechanisms, the most common being religious beliefs. Because religious beliefs are central to many people’s global meaning systems, and because death is a central arena for the enactment of religious beliefs, these beliefs are likely to play a central part in the process of coping and adjustment when dealing with anxieties about death (Park and Folkman, 1997). Thus, in confronting death, religious beliefs play a strong role in appraising the ‘meaning of the death’. If old age is a time when concern over the meaning of life gains in salience, religious beliefs may provide a particularly effective buffer against anxieties about death because it offers hope of both literal and symbolic immortality (Erikson *et al.,* 1986; Lifton, 1973). Thus, religion is claimed to not only provide comfort in times of suffering and stress, but also to offer a promise of life after death (Pargament, 1997; Leming, 1979–1980). Gesser *et al.* (1987–1988) pursued the concept of death acceptance further, proposing three different aspects of death acceptance: (1) simply accepting death as a reality which is ‘‘neither welcomed nor feared’’ – neutral acceptance; (2) accepting death as ‘‘a passageway to a happy afterlife’’– approach-orientated acceptance; and (3) accepting death as ‘‘an escape from a painful existence’’– escape-oriented acceptance. Gesser *et al.,* (1987–1988) found all three kinds of death acceptance to be higher among the elderly, and they suggested that this might be due to the fact that the elderly people in their sample also expressed a stronger belief in an afterlife than the middle-aged or younger people they studied.

Support for the influence of religious beliefs on death acceptance comes also from non-western literatures. In Indian Hindu mythology four concepts – *dharma*

(duty), *karma* (deeds), *maya* (illusion), and *atman* (soul) are intertwined and explain suffering, death, and reincarnation (Gupta, 2011).[28] The Bhagvad Gita (11-13) in Easwaran (2007) states:

> "The wise grieve neither for the living nor the dead. There has never been a time when you and I . . . have not existed, nor will there be a time when we cease to exist. As the same person inhabits the body through childhood, youth, and old age, so too at the time of death he attains another body."

Beliefs about the meaning of death as a transition to another life help people to feel less anxiety about death, compared to it being the final end (Chopra, 2006; Deshpande *et al.,* 2005). The laws of *dharma* and *karma* on the other hand are seen as helping in the preparation for afterlife (Bhattacharya & Shibuwasa, 2009; Easwaran, 2007). The practices prior to death – prayer, penance, self-denial, material renunciation – are seen as preparations for a peaceful death and a rewarding afterlife. The studies suggest that older people were less attached to their bodies, as they understood the meaning of death and, with it, the impermanence of their human body. Belief in the philosophy of *karma* gave them an explanation as to why they experience pain and suffering in their current life. The literature also states that a belief in the virtually unending cycle of birth and rebirth, a belief that one's life does not end at death but leads to a new beginning, helps to reduce the fear of death. For believers in this strand of Hindu mythology and who subscribe to the laws of *karma*, the acceptance of death is less painful as they believe that their fate is determined; so whatever bad things happen, one has to accept them (Gupta, 2011). The following sections will now explore how death is perceived and managed within the three care homes.

At all three homes, there was considerable openness to discuss dying and death. Staff often reported to residents on the progress of another resident who was very ill. Staff frequently visited the room of the dying individual. However, staff admitted that other tasks gave little time to sit with dying residents – hence many

[28] Dharma refers to rules that exemplify virtuous and ideal behaviour (Gupta, 2011). Karma invokes the concept of fate and states that one's behaviour in past lives as well as in the present life will determine future events and fate not only in the present lifetime but in future life as well (Easwaran, 2007). Maya refers to distorted perceptions of values and reality that can inhibit the growth of a person. Maya also refers to people's inordinate attachment to wealth, fame, and even the human body. Atman (soul) refers to a concept of positioning oneself not as an individual but as part of the family, community, and the universe (Bhattacharya & Schoppelrey, 2004).

deaths occurred in loneliness. Residents were, however, discouraged from calling on a dying resident. At the same time the residents with a few exceptions did not prefer to visit the dying. Interaction with staff and residents on issues related to death *reflected* three different aspects. First, that the death of a fellow resident served the function of grappling with the inexplicability and the 'finality of a resident's own death' (*aplea mornacho xevott).* Secondly, residents feared the final indignities of infirmity and so wished to die without being a burden on others, and remaining in control till the end. Lastly, residents' experiences of dying were closely related to their religious beliefs (*sastru bhavarth*) and the performance of their last rites (*mornacheo challi*). This also aided their 'preparation of death' (*mornachi toyari).* These three aspects will be briefly discussed and illustrated below.

9.5.1. Finality of death

Death in the care home served the resident as a reminder of his or her own mortality (*aplea mornacho xevott)*. Death was neither feared nor denied as gathered from interactions with the residents and staff. None of the residents indicated that they feared death; a few among them reported that they had feared death when they were younger but no longer did so.

> *"I have no fear of death (moron) nor do I feel any deep sense of grief at the death of another although I feel sadness and sympathy for when they are ill..." (Felix, Resident, Religious home)*

> *"When someone dies in the home, I feel it may be my turn next…but it does not scare me…. I believe I will be in heaven with no more miseries (Alice, Resident, Government home)*

> *"When Lily (Resident) died, I felt very sad…poor thing she had no family come to see her and the same with my roommate Felcy…poor thing she was deaf and dumb but always had a smile on her face…I am not scared for myself; I have no one who will mourn for me, I await my final journey." (Leena, Resident, Religious home)*

> *"When the residents are ill they are shifted to the hospital section, right…I go to see them sometimes if my health permits…when they die we hardly get to see them, as their families come and take them quickly or they are shifted to the morgue. I hope I die when I am in good health" (Rajan, Resident, Private home)*

> *"This place is for older people, so in a way when you enter you know you will die soon (rokdo mortolo)…and then when you see people around you dying quickly, you are convinced of it" (Valerian, Resident, Government home)*

Interviews with staff revealed similar attitudes:

> "*They (residents) do not mourn a colleague's death (moron)… They are very quiet, though…some of them do not eat food on that day…" (Deepa, Staff, Private home)*

> *"Except for Sapna (resident) none of them shed a tear. Sapna cries for everyone…" (Savita, Staff, Government home)*

> *"They are very quiet the whole day. If the funeral is held from the home, most of them stay in their rooms. They do not stay a long time with the body."(Jeanette, Manager, Religious home)*

The lack of grief displayed by fellow-residents when one of their members dies matched the feelings of staff themselves, who agreed to feeling very little grief:

> *"Over time you learn to feel detached and then you do not feel the tragedy of a person dying" (Kareena, Staff, Government home)*

The absence of grief and mourning indicate perhaps the social irrelevance of most residents in the care homes. At the same time, the fact that many of the residents were ill and were eventually going to die was clear to the staff and management:

> *"There is so much death (moron) around here; everyone has to learn to cope with it" (Jeanette, Manager, Religious home)*

Although there were a variety of attitudes among residents towards their own dying and death, most of them had thought about the likelihood that they would die soon. Some residents noted, usually briefly, that they had made preparations for their own death (e.g. they had made practical arrangements for their funeral or had made a will) and/or discussed this with their families and the home.

> *"Since I am getting on in years I think about death* (*mornon) occasionally. However, I have done all the preparations (bondabost) made a will and written a letter to my family to explain about what I want about things to do with my money*

and details about the house." (Arjun, Resident, Private home)

"I have told my family. I want all the religious rituals after my death (*mornon). I have even left my own money for that. It is very important to me." (Madhuri, Resident, Private home)*

"When I entered the home, the manager had asked me about my funeral arrangement as I had no family, right. So I told them to take care of it. So, in my mind I know, if not anything else, I will have a proper funeral from this place...I am very relieved about that" (Leena, Resident, Religious home)

The above accounts demonstrate a pattern among the respondents, who seemed to be unafraid of death. However, as the next section will evince, the fearless attitude was evaded when discussing the dying process.

9.5.2. Fear of the process of dying

The 'fear of the process of dying' *(mornachea vevarachi birant)* was an illustration of the importance attached to the physical aspects of dying both by the staff and residents. Residents were concerned about the possibly unpleasant nature and process of their dying.

"I hope not to die in a messy or painful or unduly protracted way. But, I don't mind at all the idea of being dead." (Violet, Resident, Religious home)

"My only wish is to die when my hands and legs are working…I do not want to get bedridden…it would kill me in the worst way possible" (Ignatius, Resident, Government home)

"I see the staff being stressed about bed-ridden residents. They sometimes grumble, it is only human…but I do not want to be a burden on anyone. I do not want to be bed-ridden for years" (Milena, Resident, Government home)

"When someone gets bedridden or terminally ill, they transfer them to the hospital clinic on the other side. It is terrible to be there. I visit people there, daily; most of them were transferred from here and now they are waiting for their death (*mornon). I really do not want that. I prefer going in one shot" (Sunil, Resident, Private home)*

Residents in many aspects saw life as a burden for themselves or others in the care home and hence saw death as a release. Thus, they manifested their fears towards the process of dying:

> *"People who are suffering and have no hope should pray for* (*mornon) death, I would do the same" (Carmen, Resident, Government home)*

> *Reggie expressed a fear of* (*mornon) death, though not so much about his own death as of being in a room with someone who was dead. 'I cannot think of waking up in a room where your roommate may be dead during the night'. It will surely scare me. (Field notes, Religious home, July, 2011)*

> *"I hope I live for another two years and die. I am 76 now, I have started feeling weak. I know I will not be able to go for more than two years…..If I get bedridden and crippled, these people will kick me and throw me around. I have seen the desperation of other bedridden residents. I do not want to be treated the same...I pray to God to die before any sickness" (Lactacio, Resident, Government home)*

The fear of the process of dying was also expressed by the staff. However, this did not concern the residents but the staff themselves. A mention of this is important at this juncture as it is important to understand this dying process from the point of view of those most closely associated with the residents:

> *"We try to be with a dying resident but we can only do so much. We have our other tasks to finish. We need to take care of other residents too, their meals and baths." (Lucy, Staff, Religious home)*

> *"We are very tolerant with a dying resident. We try to spend as much time with them as possible. We try to keep them as clean as possible. They are in the bed all day. The other residents are aware of this, but we all keep it quiet. We hardly talk about death* (*mornon) to the dying residents" (Deepa, Staff, Private home)*

> *"If a resident dies when you are on duty, you have so many formalities to go through. You have to send for the doctor, send the body for post mortem, contact the family and fill in forms…it can get very depressing, though eventually you get used to it"(Kareena, Staff, Government home)*

> *"Last year, I was on the shift alone. It was Ganesh Chaturthi or something. That man was almost dying; he dirtied the bed and everything. I cleaned up, had to pacify other residents, call the doctor and wake the nurse. It was terrible. I hope I am never alone on night shifts again, especially when someone is dying. It can be really difficult." (Prabakar, Staff, Government home)*

> *"If the resident has a family we immediately contact them, if not we conduct the funeral according to the religion of the resident. The other residents sometimes join, but we do not allow them too close to the dead resident. We cover the resident with a white cloth, including his or her face" (Gabriel, Staff, Government home)*

The performance of care at the time of death could also be interpreted in Goffman's terms as impression management in that staff are concerned to appear to be acting with sensitivity, dignity and courage (Goffman, 1959). However, there were also staff who tried to avoid death and explained to me that they were afraid of being present at a death or immediately afterwards. These staff also told me that they were afraid to be the only member of staff present at night in case there was a death. The examples from data cited here suggest that the routines and procedures in most homes shape the extent and nature of care, particularly when residents are dying and after death. They underpin the performance surrounding death and dead bodies and can be seen as a ritual which structures how people behave.

9.5.3. Preparation for death

There were no formal facilities present in the home to help residents and staff prepare for or to 'deal with dying and death' (*mornachi toyari*). As a result residents were seen seeking their own coping mechanism. Religion which played an important part in many of their lives was the most popular mechanism used. A range of descriptions were given to describe their religious beliefs (*sastru bhavarth)*. The residents included committed Hindus and Christians, those who were not particularly religious but who believed in an after-life, and those who blamed God for their present miseries. The relationship between *sastru bhavarth* and 'beliefs about death' (*mornacho alocen*) and 'belief of life after death' (*morna upran jivitache alocen*) varied. More women than men indicated a belief in the after-life and, in line with

Davies (1991); a quarter of research participants interviewed indicated some belief in reincarnation.

Responses from residents who indicated a strong religious belief (*sastru bhavarth)*, related it to a strong belief in an after-life (*morna upran jivitache alocen*) which would be positive.

> *"I believe God will take care of my soul when I am dead and gone" (Violet, Resident, Religious home)*

> *"This life of us is just a journey, a preparation for what is to come after death…heaven (sorg)" (Milena, Resident, Government home)*

Maria stated that she had been a church member all her life but now was beginning to give up her belief in God because of her bitterness towards her deteriorating physical condition:

> *"How could he let this happen to me? I am almost crippled. Sometimes I feel guilty for grumbling so much too, I wonder whether I will ever go to heaven" (Mary, Resident, Religious home)*

> *"I believe in Purnajanam (Rebirth)…not sure whether God is responsible for it but I know your karma surely is. What you do in this world and how you treat people will determine your next life…I know I will continue to live but not sure in what form." (Arjun, Resident, Private home)*

On the other hand, residents who did believe in God and were not sure of afterlife had a different tone:

> *"He (God) has put me through enough miseries….I just want death now, nothing else" (Gajendra, Resident, Religious home)*

> *"Does God exist? All my life I was made to believe he does. I was so strong in my faith and did good all my life. I went to the temple daily, fasted twice a week, did all the prayer offerings (pujas) and all other religious stuff but what did he give me in return? Now I am practical; I will not allow all these false philosophies to dictate to me. I will die when my body cannot take it anymore and that will be it" (Gopi, Resident, Private home)*

Spirituality (*Bhoktiponn*) was also seen by some residents as helping them to make preparations for their final departure – death. The staff and management were seen to be assisting these preparations.

In chapter 6 (see page 159) I illustrated Madhuri's case, where she perceived her entering the homes as going on *Sanyas (*renunciation*)*. The same account can also be used to demonstrate her preparation for departure:

> *"….I had fulfilled all my other roles and now it was for renunciation. This place with all its rules and regulation provides a perfect place for Sanyas…you see all the others talking and wasting their time…they do not know how to overcome these worldly temptations…I prefer solitude and it is very rewarding" (Madhuri, Resident, Private home)*

On a similar note, residents saw the pain and suffering that they or other residents underwent in their home as a way of preparation for a positive afterlife:

> *"All these rejection I am going through will not go to waste. I will be happy after my death" (Mary, Resident, Religious home)*

> *"She is so miserable, she has been bedridden for a long time – maybe 3 years. She must have done bad things in her life. You know, one gets paid for her bad doings in this world – through karma. In our next life we will all be one with God" (Laxmi, Resident, Government home)*

The home was seen as contributing to these beliefs. Confessions and *pujas* (prayer offerings) were common in all three homes. Additionally, comments from staff and management further strengthened these beliefs:

> *"We encourage them to prayer and attend mass. We have compulsory prayers for them daily. They need to pray for a good death and to go to heaven" (Jeanette, Manager, Religious home)*

> *On one of my field visits in the Government home, Savita (staff) was talking to a resident and telling her. 'Whatever good or bad you do in this world you get double the amount after your death, so do good and you will get good' (Field notes, Government home, September 2011)*

The funeral arrangements *(mornachi bondabos)* and other ceremonies of remembrance that were recalled all seemed to be underpinned and shaped by

religious (*satru)* procedures (*prokriya)* and beliefs *(bhavarth*). This was true not only for those residents who were themselves religious but also for those who said that religion was not vastly relevant to them. In short, despite the difficulty in assessing in any detail the impact of their religious beliefs (*sastru bhavarth)* upon residents' perceptions towards dying and death, their accounts demonstrate most clearly the all-pervasive, but often diffuse, influence of religious beliefs.

In summary, despite differing attitudes towards the inevitability of death this was usually acknowledged without overt fearfulness and among most residents, with an acceptance, though reluctant, that they would die. The above discussion has endeavoured to convey the perception of death for older peoples in care homes in Goa by presenting evidence of the complexity of older people's attitudes towards death.

9.6. Conclusion

This chapter presented the different forms of departure (*bhairsarap)* that residents underwent. *Bhairsarap* was seen as an end to the present form of institutional life that the residents lived. For those thinking about death, this was the end of the process of institutional living and for other it was either an end to the process or a beginning of a new one. The future for residents interviewed, across all homes, was one of fear: they preferred living in the same condition, however difficult it was. They were fearful of change. They were worried for a further decrease in physical and mental functional ability. They all repeated the same idea i.e. death before their physical or mental condition deteriorates further.

Finally, the illustrations in the three sections pointed to a variety of coping strategies to deal with the anxieties related to different forms of departures. These were extensions of residents' and staff's struggle for survival (*vanzpak*), dignity (*mann)* and control (*formai)* in the care homes. Religious beliefs (*sastru bhavarth*) were used both by residents and staff as a defensive connotation when attempting to discount the relevance of life on earth and redefining the time in the institutions as one of preparation for a life hereafter. Transfer (*suvat badalpak)* of residents to hospitals (*aspitri)* or other care institutions was also used as coping mechanisms by staff. This, as explained above, served two purposes: firstly, the dilution of the number of residents who left by dying and secondly, the scapegoating of residents by

staff in order to avoid troublemakers. However, an important point to be made here is that these coping mechanism are not to be looked at from a negative angle: getting rid of these mechanisms and confronting reality does not make the care home a more satisfactory place to live in. As gathered from my fieldwork, these mechanisms are needed for one to survive in a care home whether it is the resident or the staff and they are entitled to preserve them. The limited hope, however, is that the staff are able to transfer their energies from the support of their defences – particularly those, like scapegoating, that have destructive consequences for individuals – to the provision of extra support for residents in facing the realities of the situation they are in. Lack of support in all the three care homes led the residents and staff to build their own perception of departure and find means to cope with it. Availability of this support in form of counselling and therapy would help them cope and prepare for departure better. This along with other issues will be taken up for further discussion in the final chapter on implications and concluding observations.

Chapter 10: "I hope there will be opportunities to change our lives": Concluding observations

In line with the research objectives, my study explored the experiences of residents in care homes in Goa, India. Using an ethnographic design, I observed three care homes – Religious, Private and Government – and interviewed 24 residents, 12 staff and 4 managers across them. The observations and interviews focused on residents' experiences in their residential careers which were then analysed in the form of a narrative. In this chapter, I begin by summarizing the main findings of this analysis. I then reflect on the possible implications of my study for theory, practice, policy, and future research. I end with some final reflections on the entire thesis.

10.1. Summarising the findings

> *"Our life is very regulated in here…" (Felix, Resident, Religious home)*
>
> *"I feel like I am in a prison." (Yashoda, Resident, Government home)*
>
> *"They never ask what we want.....It is just dumped on us and we have to follow it." (Sunil, Resident, Private home)*

The three care homes selected – Religious, Private and Government – represented the different forms of institutional care available in Goa. Through the process of selecting and studying these three homes, I aimed to draw conclusions about the institutional care for older people in Goa. Though the homes, as described in chapter 4 (pages 83-110), differed in terms of their origin, physical portrait, facilities, infrastructure and resident composition, the residents, as exemplified in the accounts of Felix, Yashoda and Sunil above, echoed similarities in terms of their experiences during different stages of their residential career. These different stages – pre-entry, entry, post entry, and exit – defined the process of institutional living for the residents. They have been discussed in detail in chapters 5 to 9. The conclusions that were reached in one setting were found true in the other two. These are summarised below:

The literature that I reviewed presented contradictory views in relation to family and ageing in India. On the one hand, family in India is presented as venerating old age, however, the elements of globalisation, urbanisation and westernisation are seen as weakening the unity and integrity of the Indian family system, leading to the neglect of the role and status of older people (Brijnath, 2012; Rao, 1993). On the other hand, there is increasing debate about whether this optimistic picture of the family system is accurate, with writers drawing attention, for example, to the authoritarianism of the joint family (Chatterji, 2000; Cohen, 1998; Shah, 1998; Owen, 1996; Nair, 1995). Without explicitly disagreeing with either of these views, my study focuses on the experiences of those caught between different sets of expectations, and it shows that some older people want to be consulted in what might be called the reinterpretation and renegotiating of the intergenerational contract. Otherwise, the outcomes do not accrue to the benefit of all the parties involved. The findings suggest that older people in this study experience the rupturing of the contract in their own cases as a rejection, and perceive their entry into care homes as evidence of this. As a result, they experience their entry into a care home as intensely stigmatising. Two factors were crucial: the extent to which the older people were involved in deciding whether, when and where to be admitted, and their preparation for entry into the home. These manifestations point to an ignoring of older people's choice and voice in this decision. The findings reflect older people experiencing lack of family support on the one hand, and the absence of an adequate social security system on the other. This for them evokes feeling of ageism, which facilitates stigma, rejection, inequality and prejudice against entering care homes in Goa.

At entry into care homes, abstract, material and social losses were experienced by the older people interviewed in this study. On admission residents interacted in a new social context and had to learn to adjust. These adjustments include aspects such as the demands of rules and regulations (*nem ani kaide)*, group living philosophy *(zomeani ravpachi rit*), and expectations of staff and norms of resident behaviour (*kamdaracheo chali, riti ani veyvar*). Hurried initiation (*Godbodan bhitor sorop)* into the home and lack of communication with residents by families and staff were identified as two important factors contributing to negative

experiences. Entry into the home was seen by the research participants as evidence of severed ties with the family, which further deteriorated because of infrequent visits. The infrequent contact with family members also hampered a smooth transition into the care home. Additionally, lack of appropriate counselling and support to help residents adjust to their new environment also led to negative entry experiences.

Post-entry, the residents in this study were subjected to institutional rules (*nem)* and power *(xoktti)*, premised largely on a group living (*zomean ravop)* and layered with liberal use of management and staff discretion that influenced nearly all facets of their lives. In the post-entry analysis, I have pointed to an overwhelming presence of institutional power and control over the residents' lives in care homes in Goa – examples were the structured meal and bath routines. The residents were forced to become passive recipients of these structures, as witnessed in the withdrawal or mechanical following of rules by residents. These experiences were attributed to the power structures, staff practices and social distance existing within the care homes. The discussion pointed to residents having limited autonomy (*aplo adhikar)* and choice (*iccha)* in living their own lives. The institutional identity increasingly defined the individual's identity (*osmitay)* and as a result the residents expressed feelings of desolation, isolation and dependency (*dusreachea khalla zavop)*. However, even within these dependent identities, residents demonstrated patterns of resistance. The implication is that the residents are not passive when they confront the devaluation of their identities.

Agency (*virodh)* is expressed in multiple ways and hence needs to be read within its context. This research has pointed to the scope of agency by moving beyond the binary of resistance and subordination to explore how people use various aspects of their subordination to renegotiate their position within the power structure. Thus, by attempting to re-conceive agency outside emancipatory terms I was able to see how the structures of subordination – enforced activities, weakening health, and lack of privacy – were used by the residents to achieve their own ends, however limited these might be. Yet it is important to resist the tendency to romanticise. Although a difficult process, residents in care homes make efforts to strengthen themselves against stigma and dependency. As indicated in chapter 8, everyday resistance practices do not overthrow systems or lead to emancipation. The limited

impact questions the transformative potential of agency within the structures of power (Kabeer, 2005; Abu-Lughod, 1990). In discussing agency I have consciously steered clear of the transformative aspects of agency. The residents see their commitments to the care home as time-limited; and that active residents can be (and are) excluded from the home if they are raise too much resistance or rebellion. In the context of the research constraints, it is not useful to map agency through transformations, big social changes or qualitative improvements. This, however, does not necessarily mean that there was no transformative potential in these acts of decision-making, resistance or manipulation. Are the different forms of agency in their various intentions and expressions solely directed to the present moment or is there a long term end? Do they, in Moser's (1989) terms, always focus on practical needs rather than strategic interests? Even within this general inability of acts of agency to bring about transformations, incidents such as those described in chapter 8 – where residents attempted to resist institutional power – the decision-making of one resident then goes on to benefit the lives of others within the home.

The research participants in this study pointed to their anticipated forms of departure (*bhairsarap)* from the care home – transfer (*suvat badalpak)*, hospitalisation (*aspitrin vochop)* or death (*moron)* – as an end to the process of institutional living or a beginning of a new one. Lack of mechanisms in place for helping residents and staff to prepare for, and at the same time deal with, departures were evident. This led both the residents and staff to resort to using a variety of defence mechanisms – including denial, pretence, scapegoating – as coping strategies to deal with the anxieties related to different forms of departure. These mechanisms were seen by the research participants as extensions of the struggle for survival (*vanzpak*), dignity (*mann)* and control (*formai)* in the care homes. On this premise, defence mechanisms can be seen as something positive and necessary. However, the danger that these mechanisms may have in terms of either destructive scapegoating, or residents denying the reality of their condition, needs to be considered. Hence, the need to provide support to both staff and residents in facing these situations.

By reflecting on these discussions, the general conclusion of this study is that care homes in Goa (of the kind that were explored in this thesis) do not adequately meet the needs of the residents at different stages of their residential career, and that

steps should be taken to improve these homes. By staying as close to lives in the care homes as possible, while recognizing my own positionality, a better understanding of the care environment and of residents' experiences in this environment has been advanced. With this understanding, I now turn to discuss some of the implications for theory, practice, policy, and future research. These implications, particularly those of policy and practice are not exhaustive but intended to provide a basis for further deliberation.

10.2. Implications for Theory

This study brings together four inter-connecting concepts: loss (*luksonn*), dependency (*dusreachea khalla zavop),* agency (*virodh*) and departure (*bhairsarap),* and in doing so, makes a contribution to theoretical understanding of each of them in the context of institutional living for older people. Furthermore, the study deconstructed the concepts along with its tenets within the socio-cultural context of Goa thereby contributing to a non-western understanding of these concepts, where such an understanding is limited.

The study has commented at length on loss *(luksonn*) and dependency (*dusreachea khalla)* associated with older people's entry into the care home. By doing so my study adds to the Western discourses around loss and dependency associated with entering care homes by including illustrations from a non-western perspective. This study contributes to the literature regarding the controls (*formai)* in care homes, and the standpoints of the residents residing therein. It is evident that a number of issues suggested in the literature as barriers to adjustment to residential care, such as living with rules and regulations *(nem ani kaide),* and lack of autonomy (*aplo adhikar)* and dignity *(mann)* were regarded as important by residents in this study (Mali, 2008; Lee, 1999; Iwasiw *et al.,* 1996; Thomasma *et al.,* 1990; Brooke 1989; Goffman, 1961). At the same time the significance of cultural influences in the experiences of the older people has been uncovered in this study. It was observed that the Indian values of spirituality (*bhotiponn*) and collectivism (*somudayik jinnem*) have made it easier for the residents to remain open and accept the institutional way of living.

Through reading agency in situations which are primarily of constriction and subordination, this study contributes to the strand of research which tries to

understand the agency of people who seemingly have little control over their lives (e.g. Kabeer, 2005, 1999; Jeffery and Jeffery, 1996; Abu-Lughod, 1990; Scott, 1985). By looking at agency in a research context which has been largely characterised by dependency narratives, this study complements this literature and provides scope to understand agency which goes against the grain. Residents of care home do not passively accept their dependency; they resist the normative definitions of institutional care. By constructing their own lives within determined conditions they are creating spaces and ways of speaking and acting out.

Most of the literature on institutional living discusses the pre-entry, entry and post-entry phase. Very little literature has discussed the exit phase or departure of residents from care homes. This study, besides discussing the perceptions of departures that residents have, has also looked at the defence mechanisms used by residents to cope with these inevitable forms of departure. Additionally, the study has tied all these constructs into a narrative in the context of a developing country.

Finally all the above contributions are to be placed within the narratives of older people brought out in this study. By mapping their perceptions and presenting their narratives I have recognised them in their own right within their social context. By doing so, the study adds empirical details to make the understanding of the different concepts used richer and more grounded. Additionally, in the exposition of post-entry themes – dependency and agency – I make use of the everyday life of residents as the site of my enquiry. It is in the everyday life of the people that the meanings, perceptions and norms emerge and they can only be understood in all their complexity by looking at the everyday. By using the everyday as the prime site for understanding the main themes, I have added to the body of ethnographic literature which explicitly or implicitly explores the everyday and documents its importance.

10.3. Implications for Practice

From the findings of this study, many recommendations for practice can be deduced, some specific and some general. However, I will concentrate on three implications which are imperative to any positive change that needs to be brought in the lives of older people in care homes in Goa – support, change in care approach and training:

10.3.1. Support

The findings revealed forced and rushed admission of older people into care homes. Many residents revealed that they were neither aware nor prepared for this entry. After admission, family members rarely visited their older relatives. All these conditions negatively impacted the residents' experiences of care homes. Therefore, a needs-based care assessment involving the families and the older people should precede admission into care homes. An older person's choice should be ascertained and upheld in devising a care plan.[29] Support should be made available in helping the older person through this process. This could be in the form of counselling support provided by the care home, the Government or a voluntary organisation.

Entry to the care home was associated with loss and with expectations on the part of management of a quick submission to rules and regulations. The role of the management is important in improving this practice. A slower process of transition, accompanied by regular communication with the residents and support to meet their adjustment, should be good practice. Again, counselling support should be made available to residents at entry to aid their process of transition. This would require specialist staff to be hired in the home to provide support for the residents, not only at entry but thereafter. Alternatively, services from NGOs like HelpAge India could be designed and sought for this purpose.

An open door policy should be maintained by the care home, rather than strict visiting hours, in order to encourage family visits. Family members should be contacted by the care home if visits are infrequent. Family members should also be invited to participate in the activities and events at the home. The importance of family visits in helping the residents to make a connection to their previous roles should be stressed at all times. Some families might not be immediately available to care, but they play a valuable role in financing, sourcing information, procuring supplies and providing emotional support. Among others, this could include contributing to providing telephone and internet facilities in care homes for residents to maintain regular contact with their families.

[29] A written statement based on the needs-based assessment, setting out the care and support that a resident would receive (Department of Health, 2001).

The block treatment and regimentation of the rules and regulations constrained residents from exercising their choice and autonomy within the homes, creating dependency and depersonalisation. The study revealed that many opportunities can be created to provide residents with a choice and to enable them to make decisions about their own affairs. This could involve residents in matters of daily management such as meal and bath times, the question of restrictions on opportunities to pursue leisure interests outside the home, choices regarding social interaction in the care home, decisions regarding physical presentation of the residents (haircut, clothes) and the rules of bringing personal possession into the care home.

Similarly, for residents to preserve their individual identity, management practices in relation to the idea of privacy needs attention. There is a need to understand the issues surrounding privacy, for instance to ensure that residents' bedrooms are respected as private spaces and the residents need for individual space. In addition, residents should have control over decisions regarding their own bodies. Various recommendations could be suggested in this regard. Room and bed dividers could be built to provide privacy and individual space to individual residents. Equally, outings could provide residents with opportunities that make residents feel that they are not being watched all the time. Care homes could also offer space in which residents can form relationships as well as potentially discuss issues related to the institution which in turn could provide a platform in influencing the care provided within the home. How this is provided remains to be seen, but the provision of physical space that entails issues of privacy and respect – for example normally requesting entry – is a step in this direction.

More attention needs to be given to lines of communication in residential settings. Lack of this can lead to social distance not only between staff and residents but also between residents and residents or staff and staff. The development of a grievance redress channel, for example, irrespective of whether grievances are real, imaginary, or a cloak for feelings of rejection or guilt was seen as lacking and necessary in the three care homes. This could also include adopting mechanisms such as staff meetings, formal and informal, and group meetings between residents and

staff. The appraisal and reappraisal of the quality of care given and received is essential.

As pointed out in chapter 9, residents and staff are left to deal with the issue of departure (through resident transfers, hospitalisation and death) on their own. Counselling and therapy mechanisms are needed in the homes to deal with issues of departure, besides a backup of external psychiatric resources. Shortage of funds and relevant professional skills will in practice make only modest solutions possible. One possible solution would be for more intensive use of religious and voluntary community services. Staff need to feel supported by a system that rewards and values the work they do. Support in the form of consultation and counselling should be available to both staff and management to help them with their emotional work with the residents.

Setting up of a Care Commission consisting of different stakeholders (older people, staff, management, families, experts), which would take responsibility for all the care homes could play a pivotal role in improving residential care in Goa. Regular assessment could be conducted by the committee, for example, periodic inspection which would involve talking with residents should be encouraged. However, if this is perceived as taking place too frequently then staff may feel that they are not trusted. On the other hand the staff may become unrealistically dependent and encourage outsiders to take decisions. However if the visits are not frequent enough, residents may feel at the mercy of less than adequate staff. The frequency and other logistics of the assessments could be discussed by involving all the different stakeholders.

In essence, residents need to be supported by their participation in decision-making when selecting a care home, by negotiating the time of the entry into the home, by the maintenance of a support network inside and outside the home, and above all by helping them maintain their mobility and autonomy. This leads into a final implication for practice – the need for public awareness (also known as ‘sensitisation’) programmes that would inform, support and empower older people, to know their rights, to seek help when necessary and avail of resources, policies and programmes that would give them access to better life opportunities. An awareness of this could be generated by the Government and care homes in collaboration with

the media, religious and voluntary organisations and NGOs through advertisement campaigns and public talks similar to successful programs about infant and child care in India.

10.3.2. Change in care approach

The findings revealed a need for a change in care approach on the part of those working with the residents, directly and indirectly. My research pointed to the failure of the medical model and indicated a need for emotional intimacy and a person-centred approach to care to be developed and encouraged while caring for older people (Wiersma, 2007; Brooker, 2003; Laing, 1971; Goffman, 1961). Acknowledging the pressure of work on the staff, my study nonetheless identified a multitude of opportunities throughout the workday in which management and staff can help build emotional intimacy and a person-centred approach to care – during care tasks. By being with the resident in an attempt to understand his or her lived experience provides staff and management with a unique opportunity to create emotional intimacy that is appropriate to the level of physical intimacy that is required in the relationship. The relationship between management and staff and the residents should not be viewed as a subject-to-object relationship as was the case in my study, but as a subject-to-subject relationship, in which the staff can willingly enter and embrace the resident's experience (Mitchell, 1991). As Wiersma (2007) places it, the focus in doing this is not on 'diagnosing' the individual, but on listening to his or her perspective on what is occurring, attempting to elicit meanings on care and the care encounter. What would make a resident feel safe? What would make a resident feel valued? What can staff do to affirm the resident and his or her experiences in the care home? How can this be shown through body language and communication?

Changing from a bounded relationship of care to an emotionally intimate, person-centred approach to care requires staff to engage in reflective practice and to know themselves, their values, and their beliefs (Wiersma, 2007). Reflective practice is a vital component of person-centred approach to care (McCormack & McCance, 2006). Staff need to examine their views and to interrogate whether they even wish to make the commitment to care that involves being with the person. For many staff, caring for older people brings them face to face with the realities of ageing and gives

them a vision of their own future (Twigg, 2000). This, too, needs to be reflected upon as part of a person-centred approach to care. What does it mean to get old? How am I as a staff member different from, and similar to, the residents? The change to a person-centred approach to care requires substantial emotional commitment on the part of staff and management. Thus, a person-centred approach to care requires a caring environment in which this change might occur. Such a caring environment would include support on one hand (as discussed in the section above) and training on the other (which will be dealt with in greater detail below).

10.3.3. Training

The absence of management and staff training across the three homes has been highlighted in chapter 4 (see pages 94-98). Each formulated their own concept of residential care and used whatever experience and skills they had acquired elsewhere to deal with the problems that arose. Induction and regular in-house training for staff and management are step in the direction of a positive change. Induction training based on minimum training standards which are part of the wider commitment to improve care homes should be devised for staff across all the care homes. Refresher sessions and regular feedback are needed to maintain these improvements.

Two types of management training can be suggested for managers: First, in-house training which provides everyday opportunities to manage group relations in the home. This would involve training on the nature of authority and the interpersonal and intergroup problems encountered in exercising it (Miller and Gwynne, 1972). The second type could aim at bringing managers of different homes together to tease out common issues and work together to find more effective ways of carrying them out. Staff training could entail intimate care of residents, moving and handling, resuscitation, health and safety regulations, and communications training (Department of Health, 2001). The idea is not to create a tick box culture of whether the staff and management are trained or not but so that older people are not looked after by untrained staff and management who have no idea of what they are doing. Though all the types of training mentioned above are important and should be focussed on, communication training is most necessary as derived from my findings particularly if a person-centred care approach needs to be encouraged.

For residents in this study, interactions with staff were the main source of communication they had, particularly because of their limited contact with family members and friends. However, the findings in my study showed that these opportunities were limited to care tasks such as while residents were helped to eat, walk or bathe. Even during these tasks some staff would undertake these activities without even greeting the person, explaining what they are going to do and obtaining their permission before proceeding. The illustrations in my chapters showed the staff using patronising or infantilising styles of speech that featured exaggerated tones, inappropriate personal pronouns, such as 'we' and 'our' instead of 'you' and 'your' and unsuitable endearments such as 'dear' 'good girl'. This way of talking is described by some scholars as 'elder speak' (Williams, 2006; Williams *et al.*, 2003). Poor communication in relation to my study also included making critical comments about residents within their hearing or carrying on conversation from which the residents were excluded. Finally the organisational culture of the home, that stresses the completion of tasks, should no longer be seen as more important than spending time communicating with the residents. It is imperative for staff to develop their communication skills when communicating with the residents. The target of communication training is to help listen effectively to someone talking about a sensitive topic or difficult experience, break bad news as sensitively as possible, or communicate with a person who has communication difficulties such as those arising from medical conditions like dementia or following a stroke. Alongside verbal communication, the training should also focus on non-verbal forms of communication. This is for the benefit of all staff but particularly those with language and cultural barriers like in the case of the staff from the Religious home in my study. This can include the appropriate use of non-verbal forms of communication such as eye contact and use of touch. The ultimate aim should be to make the resident become more independent and exercise greater choice (*iccha)*. This can lead to improvements in older people's experiences provided training is sustained and reinforced by individualised supervision and feedback (Moriarty *et al.*, 2013).

10.4. Implications for Policy

The implications for practice can be further realised with support from policy initiatives. The findings of this study provide ideas for those areas in which further policy measures can be developed – some immediate and some long term. By reflecting on my finding, I have concentrated on four aspects where policy implications could be vital – supporting families, setting minimum standards for the running of care homes, NGOs and advocacy.

10.4.1. Supporting families

Many residents in this study expressed a preference for home-based care as is evident from chapter 5 (see page 134). One way forward in this regard is to target more resources at supporting families so that care can be continued at home. Appropriate policies in the Indian context are those that would encourage the traditional values of family care as well as support for co-operative efforts between various stakeholders. This can be accomplished, firstly, by additional support for families who take care of their ageing relatives, and secondly, by providing financial support for voluntary agencies who are trying to assist families in taking care of their older relatives. This could include providing short-term respite care and in-home support services (Brijnath, 2012). Such an intervention would need to be piloted in order to gauge the effectiveness and uptake of respite care, and such findings would have salience not just in Goa and India but also in other countries in South Asia where demographic transitions and changing typologies of elder care and family structure are also being experienced.

10.4.2. Setting minimum standards for the running of care homes

My research has pointed to care homes in Goa operating on their own convenience and judgement while providing care for older people. Hence, besides setting a care commission as suggested in the previous section, a policy indicating national minimum standards for care homes needs to be set out. Though these standards should be applicable to all care homes, they should however acknowledge the unique and complex needs of older people and the additional specific knowledge, skills and facilities needed in order for a care home to deliver a person-centre service (Department of Health, 2001). The aim should be directed towards giving choice and

voice to the older people in care homes. There are a number of international documents – some general and some specific – setting regulations and standards for care homes which have been drafted in this line. The general documents include the United Nations Declaration for Human Rights (1948), Covenant on Economic, Social and Cultural Rights (1966), United Nations Principles for Older Persons (1991), Madrid International Plan of Action on Ageing (2002) and the International Policy on Ageing and Older Persons (2009). The specific documents in relations to care homes include the Care Homes for Older People (2001), UK, Long-Term Care Homes Act (2007), Ontario, and the Charter of Residents' Rights and Responsibilities (1996), Australia. By relying on some of the themes from these documents within the cultural context of Goa, the standards could be grouped under the following key topics, which highlight aspects of older person's life identified during this study. I have also listed areas derived from my findings, which could fall under each of this topic.

1. Choosing and preparing to enter a care home: Needs based assessment, trial visits, preparation for entry, discussing the implications of entry and providing opportunity for expressing apprehensions.
2. Health and personal care: Privacy, dignity, death and dying, care plan, and medication.
3. Daily life and activities: meals and meal times, flexible and varied routines, community and contact, autonomy and choice, voluntary and religious organisations.
4. Grievance Redressal: Rights, grievances and protection.
5. Physical Environment : Accessible, safe and well maintained home, provisions for shared facilities and individual rooms, lavatories and washing facilities, adaptation and equipment's (aids, hoists, and assisted toilets and baths), communication aids, call system with accessible alarm facility, ventilation, lighting, personal belongings, Hygiene and control of infection,
6. Staffing: Staff complement (numbers and skill mix of staff), qualifications, Recruitment and training,

7. Management and Administration: day to day operations, ethos, quality assurance, financial procedures, residents money, staff supervision, record keeping, safe working practices,

This list as pointed earlier is not exhaustive but a starting point for deliberation for different stakeholders involved. Multiple challenges, ranging from lack of resources to lack of infrastructure, from behavioral barriers to policy hurdles can affect the feasibility of the above recommendations and therefore need to be considered during such a deliberation.

With the large number of vulnerable groups in India in general and Goa in particular accompanied by the fact that it is still a developing economy which is struggling to deliver basic welfare services, control life threatening diseases, and prevent maternal and child mortality, the above suggestions can be viewed as unaffordable luxuries. Even schemes like the National Social Assistance programme launched in 1995, and the Government's monthly financial assistance for those who are destitute do not cover all people requiring such help (Prakash, 1999). Furthermore, the development of inadequate infrastructure in care homes – illumination, bed alarm system, room dividers, handrails, visual and auditory alarm system, communication facilities, proximity to communities, western toilet facilities, provision of counselling and therapy sessions, and medical assistance among others -- need to precede the above policy recommendations which will put a great strain on the already struggling economy. Although the above recommendations can be a long-term powerful economic empowerment tool, the state may not be able to afford them in the present and hence give it a low priority.

Additionally, the importance attached to family care of the elderly and the associated fallout of stigma attached to entry into a care home as expressed in various parts of this thesis may negatively influence the implementation of the above recommendations. As mentioned in chapter 1 (page 6) civil society organisation and policy makers question and challenge the development of care homes for the alleged reason that such development would make it easier for children to avoid their responsibility for taking care of their parents. The stigma attached to care homes may further negate any venture directed to their improvement.

Finally, the biggest potential challenge may be a lack of political will. More often than not, competing priorities, short-term thinking or limited budgets hinder progress. Authorities in India have largely ignored the challenges of the country's ageing population, much of the emphasis of the Government in terms of care and welfare has been on women and child programmes with an emphasis on controlling population growth (Prakash, 1999). Population ageing has not been a priority area hence policy makers in India and Goa may be reluctant to launch large-scale efforts to promote extensive care initiatives because they are uncertain which would provide the best returns.

The practical implications of the population ageing for India, however, are far-reaching. The numbers are increasing, the resources are limited and perceived social priorities lie elsewhere. Hence, the response to such demands has to be well orchestrated, multi-sectoral and based on systematic planning (Kalache & Sen, 1998). In lieu of these challenges the emphasis is now on enlisting the cooperation of the NGOs as well as the community, advocacy to raise policy makers' and civil society awareness of the multiple issues related to ageing and care homes and further research on these issues. Professionals, politicians, voluntary workers, NGOs and the general public need to be targeted by these awareness-building exercises. This will be taken up for further discussion in the following sections.

10.4.3. NGOs

The findings of the study should also inform policies for NGOs. The Government of India has attached considerable importance to the role of NGOs in extending social welfare services. In the realm of elderly care, NGOs are associated with different stages of planning and implementation. They set up care homes and, to a lesser extent, train personnel (Kurup, 1989). HelpAge India (Goa) has done a lot of work with and for older people in Goa. However, many of these efforts are small scale and local in nature, serving very limited number of older people. There is a need for NGOs to co-ordinate with families, government bodies and care homes in order to develop good practice in the care homes. Elder abuse is another area that NGOs should focus on. Family counselling services need to be established to support both the older people and their family members. Hotline telephone services could be started by NGOs to register, monitor, and redress the situation of elder abuse.

10.4.4. Advocacy

Moving to a person-centred care approach require advocacy at the policy level. Neither the staff nor the residents are organised politically in India. As such, advocacy for change at a structural level is still in the hands of relatively few. The system, however, is unlikely to change itself. Therefore, every stakeholder – older people, policy makers, families, members of civil society, staff, management, and NGOs, – who wishes to see changes made, has a responsibility to become politically active to see that these changes take place. Finally, all levels of government, working with the media and NGOs, have to promote discussion about the challenges of population ageing in India and what standards should apply to the efforts of individuals, families, and organisations to meet the needs of older people in Goa and India on the whole in present times. The implication is not for all these agencies to work in isolation but in an integrated effort towards a more collaborative delivery of care.

10.5. Implications for future research

In chapter 3 (see page 72-74), I identified certain missing links such as family perspectives and speaking on topics related to sexuality, which would have been interesting to follow through and would probably have been explored in greater depth if more time and resources for my fieldwork had been available. At the same time, this study has answered certain questions to enrich our understanding of residential care of older people. Like every new study it has raised numerous queries to pave the way for future research. In trying to limit myself I will spell out three areas which could be explored further as a by-product of this study:

1. **Family:** Two issues relating to family arise from this study: firstly, what are the experiences of family members who admit their older relatives into care homes and how does this change across the residential career of the resident? Secondly, the brief discussion of elder abuse in chapter 5 (see pages 128-129) illustrates that there is a need for more documented information of cases of various types of elder abuse in families. There is a need for in-depth studies on the antecedent and contextual factors influencing the various forms of elder abuse. This will enable appropriate interventions to be planned and executed, at least to reduce their severity, if not to prevent them altogether.

2. **Theorising resistance:** Two questions relating to resistance will help further theorise resistance in the context of older people in care homes. Firstly, what are the facilitating conditions for resistance to power? Secondly, how do the resistance practices vary across the residential career of the resident? Does the frequency and manifestation change with the number of years spent in the care home? Is there a conceptual boundary between resistance and resilience?
3. **Gender:** Gender and gender roles need to be further explored in care homes. Currently much research assumes a (de)gendering process or does not explicitly examine gender (Russell, 2007; Silver, 2003). The argument is that loss of socioeconomic power and status among older people has created an arena where patriarchal rules and gender-based expectations have been altered, providing the context for new (de)gendered identities. There is a need to analyse these assumptions regarding gender and age representations further, particularly in the socio-cultural context of India. By comparing different views of ageing – psychoanalytic, feminist, and that of older people themselves – future research can explore how they reflect underlying ideologies about age and gender within the purview of social construction.

10.6. Concluding observation

In conclusion, it is evident that much work remains to be done in ensuring a good quality of life for residents in care homes in Goa. Care homes for older people are not places to die but places to live and live well. Residents in care homes are individuals who deserve to live out the remainder of their days with dignity *(mann)* and respect *(sammann)* in an environment that is empowering and enabling, not belittling (Murphy *et al.*, 2006). To date, little attention has been paid by management, policy-makers and other stakeholders to raising the quality of life in care homes in the area. This study has pointed to a change needed in the role played by policy-makers, management, staff, family members and society as a whole in developing quality of care and life for older people in care homes. In this regard, it is a modest attempt; a starting point for research activities to be pursued to build an evidence-based culturally appropriate aged care model for India which maintains choice (*iccha)* autonomy (*adhikar)* and dignity (*mann)* of older people. As Alice, a resident from the Government home puts it:

"Nobody is interested in our (older peoples' in care homes) lives in here. We are neglected – nobody cares about us, nobody respects us, nobody asks for our opinion, nobody values us. We suffer this each day and sometimes we try to fight it. Eventually we die either trying to fight it or surrendering to it. I do not want to be negative and give up; I really hope there will be opportunities to change our lives – to live with dignity (mann) …..If these changes do not occur in my life time, I hope they do in yours as old age is not missing anyone."

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Appendix 1: Newspaper reports on care homes in Goa

Fabricated facts
April 30, 2008
Evaristo Fernandes, Merces
This is to bring you some facts about the functioning of Provedoria. A report appeared on front page (Herald, 27 April) that Provedoria is offering succor to the elderly. This is completely fabricated and untrue. Instead now Provedoria has, more or less stopped giving financial aid to the needy because now Provedoria does not have sufficient funds to help the needy as they used to give earlier. This happens because executive officers of the Provedoria are least bothered about executing welfare schemes for the needy people and senior citizens. Many old age homes of the Provedoria are in a shambles, for example the Old Age Home at Chimbel. Even day to day diet of the inmates has been curtailed to a great extent due to poor financial condition of the Provedoria. There are instances wherein expenditure bills of old age homes, medicine bills arc left unpaid for the last many months due to paucity of funds. Iam also given to understand that Provedoria now intends to use GPF funds of the employees to disburse monthly salary to the employees. Such conditions arise due to mismanagement of Provedoria's funds by the top executive personnel since they are least bothered about the welfare of the old and needy people. There is a glaring example of how Provedoria's funds are misused by Ex-Director of Provedoria and other executive body by using Provedoria's official vehicle for private purposes. Even to go for a cup of tea and for personal marketing, Provedoria's vehicles are being misused as their private vehicle. I would request Herald Reporter's Team and HCN Goa's topmost News and Entertainment channel to give a surprise visit to all the aged homes and Orphanages centres and judge/see themselves the conditions of the old age homen building and the inmates residing in the said building specially at Chimbel, Margao, Chinchinim etc. Also enquire with the inmates what facility they are getting. I could not believe the reports appeared in Herald wherein Director and Assistant Director of Provedoria gave untrue stories to the HCN Crossfire Debate where in reality it does not exist at all. I would earnestly appeal to the management of Provedoria to sincerely work towards welfare of the poor people instead of giving bogus, fictitious and untrue facts to the news channel.

The Voice of Goa – Since 1900
Herald

ALL'S NOT WELL IN PROVEDORIA HOMES

April 28, 2012

TEAM HERALD

teamherald@herald-goa.com

PANJIM: Members of Goa Citizens Welfare Trust (GCWT) have threatened to go on strike to protest the inhuman treatment meted out to senior citizens and children lodged in the government-run Provedoria homes, where besides unhygienic conditions, inadequate food, helpless inmates have even been abused and assaulted by drunken staff.

Trust Chairman Michael Fernandes said their memorandum to Chief Minister Manohar Parrikar on April 8 apprising him about the problems faced by inmates and seeking action against the officials, has not evoked positive results.

"We understand the government is just taken over but at the same time we cannot ignore the inhuman treatment meted out to needy inmates. There is no action taken on our memorandum yet," Fernandes informed.

GCWT urged the chief minister to conduct an enquiry against the management of Provedoria starting with then director Vinesh Arlekar, Assistant Directors Antonette Sequeira, Vishwas Nayak and Assistant Engineer Shrinivas Rao for negligence and violation of human rights.

The Trust cited several instances supported with photographic evidence of ill treatment meted out to inmates, and their absolutely poor and unhygienic living condition.

The complaint is based on surprise visits conducted at all Provedorias including 11 orphanages following complaints by social workers.

"The inspection revealed pathetic infrastructure such as beds infested with bedbugs, no safety railing for senior citizens, no emergency and alarm systems, overflowing toilets and clogged sewage tanks, unhygienic premises, nutritively poor and less quantity of food are just a few of the problems ," Fernandes mentioned.

He added, "There are no proper sleeping arrangements as most beds are without mattresses and bedsheets. No water beds are available in any of the old age homes for bed ridden inmates."

The Trust members also complained that a lady inmate lodged in the Chimbel mental asylum was abused, assaulted and partially stripped off her dress by an alcoholic staff member.

The members have identified the staffer as one Rakesh Hadgaonkar and demanded action.

The Voice of Goa – Since 1900
Herald

Parrikar criticised for poor conditions at old-age homes

January 1, 2013

MARGAO: Chief Minister Manohar Parrikar on Monday came under severe criticism from a quarter unconnected to politics.

Apparently moved by the plight of the inmates in the government-run old age institute at Majorda, the Goa Citizens Welfare Trust has said it have lost confidence in the chief minister for having failed to take care of the elders in the 11 homes run by the Provedoria. “It has been nine month since we met Parrikar with video footage of the pathetic situation at the old age homes. Nothing has changed since then. Why is the government not protecting the elders housed in the old-age homes? They also deserve a dignified life,” remarked GCWT Chairman Micheal Ferns.

If Ferns is to be believed, the Trust had donated 30 water mattresses to the old age home. But, he could not find a single such mattress at the Majorda old age home, even as a woman inmate with leg injuries was found struggling on a normal bed without basis amenities.

He said if the government cannot run the old age homes, they should hand it over to people willing to look after the aged. “Here, we aren’t talking about mining or RP, but about human beings craving for attention and facilities”, he added.

Saying that the Chief Minister should pull up his socks, Ferns said the Chief Minister should take up the humanitarian issue instead of running after mining. “There has been three deaths at the Majorda old-age home. We don’t know the exact cause of death. One reason could be negligence. It is violation of the basic human rights,” he said.

Times of India

State of despair: Senior citizens suffer in silence

TIMES NEWS NETWORK

Panaji: The recent case of a 75-year-old mother Navshe Sawals who was forced to live in a public pay toilet as her son allegedly abandoned her, has brought to the fore the problems and pain faced by senior citizens in society.

The woman was abandoned in the last week of June and was rescued in an unconscious condition from a sulabh toilet at Mala last Friday morning. The Panaji police have registered an offence under the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 against her elder son.

Even as a sizeable part of Goa's population (nearly a lakh persons) is pushing 60 and beyond, their wrinkles are being accompanied with a lot of pain.

People working with senior citizens accept that the image of domestic tranquility is now being challenged by the realities of increasing abuse of the aged, especially when they are dependent on their children. They believe that there are many more Navshe Sawals, who suffer in silence as they are continuously exposed to emotional neglect and lack of physical and financial support.

"The problem is that they don't want to complain against their children, fearing that they would be in trouble or would have to undergo tension and trouble because of their complaints. They also often don't complain due to threat perception or fear," said Akbar Abdul Mavany, caretaker, Forum for Senior Citizens of India.

Mavany said that the problem has increased in recent years as the family ties have disappeared and persons who have retired from service don't have enough finances. However, a few get some financial help from the state government under the Dayanand Social Security Scheme. "But this is not adequate. Moreover, often the real needy don't get," added Mavany.

Suhas Sardessai, who runs two old age homes in North Goa, one for the poor and another for the well-to-do senior citizens said, "Sometimes the children's difficulties are genuine. They go abroad for work and are forced to keep their parents at an old age home. But some children refuse to take responsibility for their parents and find them a burden, who intrude into their privacy".

Appendix 2: Information, consent and permission letter

Information letter

Re: Permission to conduct PhD research study.

I am writing to you as a supervisor to Miss Deborah Menezes. We are seeking permission for her to conduct her PhD research using old age homes in Goa as her case studies.

Miss Deborah is researching on the 'experiences of older people in old age homes in Goa' in the context of institutional care in Goa, India. The main aim of the research is to contribute to understanding of care provided in institutions for older people in a developing country, from the perspectives of older people themselves through a case study of Goa.

To achieve this aim the study frames the following research question:

1. What are the experiences of older people in old age homes? What are the different elements of service that residents identify as significant influences on their experience?
2. How much control do institutions exert on the experiences of residents? What is the result of this on older persons?
3. Does this experience vary between service providers?

At the empirical level, the study intends to involve three different models of care management i.e. the state run, religious and private institutions for data collections. For gathering empirical data this study will undertake participation observation with older people and semi structured interviews with some residents, staff and management. It is anticipated that Deborah may observe the residents for 3 to 4 days a week for a month in each care home and then return back to conduct the interviews. Deborah will undertake the role of a volunteer helper and hence the research process will have no influence on the daily routines of the institution.

The University of Edinburgh prioritises research ethics and Deborah's proposed research has already been intensely scrutinised from our institutional perspective. To honour ethical commitments, all researchers must gain informed consent from participants, and maintain anonymity and confidentiality of all study participants/institutions during and after the research process. Deborah has successfully undergone our committee's scrutiny and will be bound by all the ethical procedures of the University.

We are confident that the research study is an ethical and productive project. It would be appreciated if could give her the permission to access your institution and extend all your support for the successful completion of her field work. Should there be any other queries with regard to her research and field work, she can be contacted at D.Menezes@sms.ed.ac.uk . If you have any further concerns please do not hesitate to contact me.

Deborah Menezes
PhD Student in Social Work
School of Social and Political Science
University of Edinburgh
Chrystal Macmillan Building
15A George Square
Edinburgh, EH8 9LD

Title of Project: A Life Apart: Lives of Older People in Old Age Homes in Goa

Purpose: To gain an understanding of the experiences of older people in old age homes in Goa

Supervisors: Dr George Palattiyil and Professor Roger Jeffery

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Letter requesting Informed Consent

You have been requested by me to participate in this study conducted for pure academic purpose. The purpose and focus of this study is to *gain an understanding of the experiences of the older people in care homes in Goa.*

Participation in this session is voluntary. There are no known or anticipated risks to your participation in this session. You may decline answering any questions you feel you do not wish to answer and may decline contributing in other ways if you so wish. All information you provide will be considered confidential and grouped with responses from other participants.

Your responses will remain anonymous and no names will be mentioned in the report. The information collected from this session will be kept for a period of three years in *my personal password secured computer and will be destroyed after that.*

If you have any questions, comments or concerns about participation in this study, please feel free to discuss these now, or later, by contacting me *(Deborah Menezes)* at D.Menezes@sms.ed.ac.uk .

I would like to assure you that this study is ethical. However, the final decision about participation is yours. Thank you for your assistance with this project.

Yours sincerely,

Deborah Menezes

Deborah Christina Menezes
Doctoral Researcher
School of Social and Political science
University of Edinburgh

Dated: / /2011

To
.

Sub: Permission for field work at _____

Dear Sir/Ma'am,

I Deborah Menezes, am a PhD student at the University of Edinburgh, UK. I am researching on an important aspect of demographic, political and social life in Goa- the institutional care for older people. I have selected 3 homes, one each from among Government, private and religious. From among the private homes, I have selected _____ to pursue my fieldwork.

At the Asylum I will undertake participation observation with older people and semi structured interviews with some residents, staff and management. It is anticipated that I may interact and observe residents for 3-4 days a week for a month, followed by interviews. I ensure high sensitivity and respect for all the participants; my presence will not influence daily routine of the institution.

This letter is to request your kind permission to enable me to carry out my field work at _____**.** I hope for a positive response from your end.

Thanking you in anticipation.

Regards,

Deborah Menezes

Appendix 3: Scoping study questionnaire

Scoping Study Questionnaire for _____

History and motivation (ideology) behind the setting of the Home

Structure and management of the Home

Services provided in the Home

Payment structure(Finance) followed in the Home

Characteristics of people in the Home (age, sex, method of payment, number of years spent any other demographics)

Idea of a typical day at the Home for an older person (inmate)

Shifts for volunteers in the Home

Any additional information on the Home

Appendix 4: Scoping study data

Religious Homes

Sr. no	Names of Home	Place	Taluka	District	Structure/Management	Services	Payment	Capacity	Finance	Age group	Persons accepted	Average number of years	Typical day	Shifts	Entry requirements	Entry process	Type and quantum of accommodation
1	Ark of Hope (St. Vincent de Paul Society)	Candolim	Bardez	NG	Religious committee - superior general-staff	Medical care, food, television, radio, bath, prayer area	free and pay (payment varies between 1500 to 3000 (room and dormitory)	28	Donations	60-90	Female	10 years	fixed timings (Have noted seperately)	2 shifts (Day and Night)	1.Able bodied 2. above 60 3. Gurantee from family	1.visit the individual 2. confirm admission	Single, double, dormitory
2	Asilo "Dr. Rafael Pereira"	Benaulim	Salcette	SG	"	"	"	20	"	60-90	Female	8-9 years	"	"	"	"	"
3	Asyium of the Sacred Heart of Jesus and Mary	Aldona	Bardez	NG	"	"	"	45	"	70-85	Female	7-8 years	"	"	"	"	"
4	Bom Jesus Home	Nachinola	Bardez	NG	"	"	"	35	"	64-90	Female /Male	10 years	"	"	"	"	"
5	Divine Providence Home	Benaulim	Salcette	SG	"	"	"	40	"	75-100	Female	10 years	"	"	"	"	"
6	Holy Family Home for Aged	Chorao	Tiswadi	NG	"	"	"	17	"	70-90	Female	8 years	"	"	"	"	"

7	Holy Spirit Home	Moira	Bardez	NG	"	"	"	40	"	70-90	Female /Male	10 years	"	"	"	"	"
8	Isha Prem Niketan	Goa-Velha	Tiswadi	NG	"	"	"	5	"	60-80	Female	5 years	"	"	"	"	"
9	Isha Prem Niketan	Assagao	Bardez	NG	"	"	"	13	"	60-90	Female /Male	20 years	"	"	"	"	"
10	Krist Raj Bhavan	Saligao	Bardez	NG	"	"	"	15	"	60-100	Male	10-15 years	"	"	"	"	"
11	Lar Santa Margarida	Divar	Tiswadi	NG	"	"	"	30	"	65-95	Female /Male	15 years	"	"	"	"	"
12	Mae de Deus Home	Saligaon	Bardez	NG	"	"	"	20	"	60-90	Female	10-15 years	"	"	"	"	"
13	Mother Marry Haven	Calangute	Bardez	NG	"	"	"	67	"	70-100	Female	10-15 years	"	"	"	"	"
14	Nazareth Home	Navelim	Salcette	SG	"	"	"	37	"	60-90	Female	10-15 years	"	"	"	"	"
15	St. John of God's Home	Old-Goa	Tiswadi	NG	"	"	"	35	"	70-95	Female /Male	10-15 years	"	"	"	"	"
16	St. Joseph's Eventide Home	Ucassaim	Bardez	NG	"	"	"	35	"	65-85	Female /Male	15 years	"	"	"	"	"
17	St. Joseph's Home	Siolim	Bardez	NG	"	"	"	35	"		Female	10 years	"	"	"	"	"
18	St. Mary's Guest House	Nagoa, Verna	Bardez	NG	"	"	"	25	"	60-80	Female /Male	10 years	"	"	"	"	"
19	St. Mary's Home	Siolim	Bardez	NG	"	"	"	25	"	70-90	Female	10 years	"	"	"	"	"
20	St. Thomas Villa	Bodiem	Bardez	NG	"	"	"	41	"	75-100	Female /Male	13 years	"	"	"	"	"
21	Missionaries of Charity	Karmali	Tiswadi	NG	"	"	"	65	"	80-100	Female	8-10 years	"	"	"	"	"
22	Missionaries of Charity	Qupem	Quepem	SG	"	"	"	58	"	80-100	Female	8-10 years	"	"	"	"	"
23	St.Judes Helping Hand Home	Fero St.Estevam	Tiswadi	NG	"	"	"	17	"	60-84	Female /Male	7 years	"	"	"	"	"

Private Homes

Sr. no	Names of Home	Place	Taluka	District	Structure/ Management	Services	Payment	Capacity	Finance	Age group	Person's accept ted	Average number of years	Typical day	Shifts	Entry requirements for inmates	Entry process	Type and quantum of accomodation
1	"Sneha Mandir"	Bandora, Ponda	Tiswadi	NG	Trust-Management-staff	Medical care, food, television, radio, bath, prayer area	able=2000, bedridden=3500, limited free seats	able=45 bedridden=42	Donations	60-100	M/F	10 and more	fixed timings (Have noted seperately)	3 shifts (Morning, day and night)	1. certified to be mentally and physically fit. 2. completed 60 years. 3 Need of a home. 4. There is a quota allocated for bedridden and individuals with declining health too.	1. Admission form. 2. Security deposit, 3. Management reserves final right of admission	Double
2	"Sanjeevan"	Bandora, Ponda	Tiswadi	NG	"		3000 pm/limited free quota	35	Donations	75-90	F	5 to 7					"
3	Vishwanath Jagannath Trust	Ponda	Ponda	NG	"		3000 - 5000 pm/limited free seats	25	Donations	60-100	M/F	3 years					"
4	Vijaya Ashram	Vovonem,Tivim	Bardez	NG	"		3000/limited free seats	50	Donations	60-100	M/F	10 and more					"
5	Our Home	Vasco	Mormugao	SG	"		/2000/4000/ free seats	52	Donations	65-90	M/F	10 years					"

Government Homes

Sr. no	Names of Home	Place	Taluka	District	Structure/ Management	Services	Payment	Capacity	Finance	Age group	Persons accepted	Average number of years	Typical day	Shifts	Entry requirements	Entry process	Type and quantum of accomodation
1	Recelhimento de Serra,	Althino Panaji	Tiswadi	NG	Institute of Public Assistance (Provedoria) Duty Officers Staff	Medical care, food, television, radio, bath, prayer area	1. Free 2. Subsidised- pay and stay	25	Government grants	60 to 100	Female	10 and more	fixed timings (Have noted seperately)	4 shifts general - 9am-5pm 1st 8am-2pm 2nd 2pm-8pm 3rd 8pm-8am	1. 60+ age group 2. Infirm 3. able bodied 4. abandoned 5. living on public charity	1. prescribed form 2. certificate of poverty 3. Medical certificate to certify the person is physically and mentally sound and does not suffer from contagious disease 4. Inquiry by field staff 5. Admission confirmed within 10 days	Dormitory
2	Asylum of Chimbel	Chimbel	Tiswadi	NG				66		"	male/female	"					"
3	Asylum of Mapusa	Mapusa	Bardez	NG				40		"	Female	"					"
4	Asylum of Candolim	Candolim	Bardez	NG				40		"	Male	"					"
5	Asylim of Majorda	Majorda, Salcete	Salcete	SG				40		"	Female	"					"
6	Asylim of Loutolim	Loutolim	Salcete	SG				40		"	Female	"					"
7	Asylim of Margoa	Margao	Salcete	SG				30		"	Female/Male	"					"
8	Centro de Cunculim	Cunculim, Salcete	Salcete	SG				70		"	Male	"					"
9	Centro de Chinchinim	Chinchinim, Salcete	Salcete	SG				40		"	Male	"					"

Appendix 5: Interview schedule for residents

Interview Schedule for residents _____

General:

Pre-entry experience

When, Why, Who, How, Reactions and Experiences

Entry experiences

Descriptions, feelings, Reactions

Post entry experiences

Daily activities, interpersonal relationships, support they receive Experiences they like to talk about, Concerns, improvement, best things they enjoy, important things at present, feelings in comparison to earlier periods.

Departure:

Immediate purpose/goals, future, coping.

Interview Schedule for Staff

_____

- Entry:
- Individual space:
- Daily programme:
- Meals:
- Cleaning:
- Bathing:
- Doctors and Medications:
- Social Spaces:
- Future (Exit)

Appendix 6: Ethical review form

University of Edinburgh

School of Social and Political Studies

RESEARCH AND RESEARCH ETHICS COMMITTEE

Ethical review form for level 2 and level 3 auditing

This form should be used for any research projects carried out under the auspices of SSPS that have been identified by self-audit as requiring detailed assessment - i.e. level 2 and level 3 projects under the three-tier system of ethical approval that has been developed by the Research and Research Ethics Committee of the School. The levels within the system are explained in the SSPS Research Ethics Policy and Procedures document. Please tick the appropriate box to indicate which level applies to your research.

This form provides general School-wide provisions. Proposers should feel free to supplement these with detailed provisions that may be stipulated by research collaborators (e.g. NHS) or professional bodies (e.g. BSA, SRA). The signed and completed form should be submitted, along with a copy of the research proposal (or a description of the research goals and methodology where this is unavailable) to the relevant person (Head of School/Institute for proposals for external funding; Course Organiser for undergraduate student projects; supervisor or Programme Director for postgraduates) and also lodged (if possible electronically) with the School Research Administrator for forwarding to the Research and Research Ethics Committee.

Research and Research Ethics Committee will monitor level 2 proposals to satisfy themselves that the School Ethics Policy and Procedures are being complied with. They will revert to proposers in cases where there may be particular concerns of queries. For level 3 audits, work should not proceed until Research and Research Ethics Committee has considered the issues raised. Level 3 applications should be submitted well in advance of a required date of approval.

SECTION 1: PROJECT DETAILS

1.1 Title of Project: A Life Apart: Lives of older persons in old age homes in Goa

1.2 Principal Investigator, and any Co-Investigator(s)

(Please provide details of Name, Institution, Email and Telephone)

1.4 Does the sponsor require formal prior ethical review? YES □ NO □
If yes, by what date is a response required

1.5 Does the project require the approval of any other institution and/or ethics committee? NO

If YES, give details and indicate the status of the application at each other institution or ethics committee (i.e. submitted, approved, deferred, rejected).

1.6 This project has been assessed using this checklist and is judged to be
LEVEL2 × (for information to Research Ethics Committee)

LEVEL 3 □ (for discussion by Research Ethics Committee)

1.7 If Level 3, is there a date by which a response from the committee is required?

Name…… Signature……

PLEASE ATTACH A COPY OF THE RESEARCH PROPOSAL (OR ALTERNATIVELY A DESCRIPTION OF THE RESEARCH)

SECTION 2: POTENTIAL RISKS TO PARTICIPANTS

2.1 Could the research induce any psychological stress or discomfort? NO ✓

If YES, state the nature of the risk and what measures will be taken to deal with such problems.

2.2 Does the research require any physically invasive or potentially physically harmful procedures? NO ✓

If YES, give details and outline procedures to be put in place to deal with potential problems.

2.3 Does the research involve the investigation of any illegal behaviour? NO ✓

If YES, give details.

2.4 Is it possible that this research will lead to the disclosure of information about child abuse or neglect?

NO ✓

If YES, indicate the likelihood of such disclosure and your proposed response to this. If there is a real risk of such disclosure triggering an obligation to make a report to Police, Social Work or other authorities, a warning to this effect must be included in the Information and Consent documents.

2.5 Is there any purpose to which the research findings could be put that could adversely affect participants? NO ✓

If YES, describe the potential risk for participants of this use of the data. Outline any steps that will be taken to protect participants.

2.6 Could this research adversely affect participants in any other way? NO ✓

If YES, give details and outline procedures to be put in place to deal with such problems.

2.7 Could this research adversely affect members of particular groups of people?

NO ✓

If YES, describe these possible adverse effects and the protection to be put in place against them.

2.8 Is this research expected to benefit the participants, directly or indirectly?

If YES, give details.

YES ☑

The research aims to give a voice to unheard voices of older people in old age homes in Goa who may have never had a choice to express their opinion. These voices may have implications for improving the quality of care in care homes in Goa.

2.9 Will the true purpose of the research be concealed from the participants?

NO ✓

If YES, explain what information will be concealed and why. Will participants be debriefed at the conclusion of the study? If not, why not?

SECTION 3: PARTICIPANTS

3.1 How many participants is it hoped to include in the research?

40 participants are intended to be interviewed. 30 participants will comprise of the residents and the remaining will be staff. For participant observation I hope to include all the residents and staff in the three care homes I intend to study unless I am unable to get a direct or proxy positive consent.

3.2 What criteria will be used in deciding on the inclusion and exclusion of participants in the study?

For participant observation all the residents and staff will be included, however if consent is not given to the study the participants will be excluded. For interviewing 10 residents, and 3 staff from each home will be selected based on their consent. No strict inclusion criterions will be maintained however diversity will be sought. This diversity could be in terms of the payment option of the participant and the number of years the participant has been at the care home. Limited capacity of residents is proposed as a exclusion criteria for conducting interviews.

3.3 Are any of the participants likely to:

be under 16 years of age?	NO ✓
children in the care of a Local Authority?	NO ✓
known to have special educational needs	NO ✓
physically or mentally ill?	YES✓
vulnerable in other ways	NO ✓
members of a vulnerable or stigmatized minority?	NO ✓
unlikely to be proficient in English?	YES✓

in a client or professional relationship with the researchers? NO ✓

in a student-teacher relationship with the researchers? NO ✓

in any other dependent relationship with the researchers? YES✓

have difficulty in reading and/or comprehending any printed material distributed as part of the study? YES✓

If YES to any of the above, explain and describe the measures that will be used to protect and/or inform participants.

Physical or mental pressure is not foreseen in this study however if I encounter any hint of it arising at any point of time in the research I will make sure that the part of the study is withdrawn. The aim and objective of the research and the participant's role in the research will be clearly articulated verbally and in paper. At the same time freedom to withdraw at any point of time will be emphasised. All measure will be taken to avoid meeting the resident in private spaces on a one to one basis. Verbal and written translation in local language (Konkani) of the above will be the key to overcome resident's lack of proficiency in English. The researcher being an able body volunteer may put the resident in a dependent position; however my ability to empathise with them may help me overcome this issue. The consent forms and other research materials to be distributed will be printed in large fonts. At the same time verbal means of communication will be emphasised in the absence of the resident's ability to comprehend printed material.

3.4 How will the sample be recruited?

By direct contact

3.5 Will participants receive any financial or other material benefits because of participation?

NO ✓

If YES, what benefits will be offered to participants and why?

Before completing Sections 4 & 5 please refer to the University Data Protection Policy to ensure that the relevant conditions relating to the processing of personal data under

Schedule 2 and Schedule 3 are satisfied. Details are Available at:

www.recordsmanagement.ed.ac.uk

SECTION 4: CONFIDENTIALITY AND HANDLING OF DATA

4.1 Will the research require the collection of personal information from e.g. universities, schools, employers, or other agencies about individuals without their direct consent?

NO ✓

If YES, state what information will be sought and why written consent for access to this information will not be obtained from the participants themselves.

4.2 Will any part of the research involving participants be audio/film/video taped or recorded using any other electronic medium?

YES ☑

If YES, what medium is to be used and how will the recordings be used?

Audio tape recorder may be used while conducting interviews in some circumstance with prior permission of the respondents.

4.3 Who will have access to the raw data?

The researcher and her supervisors

4.4 Will participants be identified?

NO ✓

4.5 If yes, how will their consent to quotations/identifications be sought?

4.6 If not, how will anonymity be preserved?

Anonymity of the participants and the institutions will be maintained throughout.

4.7 Will the datafiles/audio/video tapes, etc. be disposed of after the study?

NO ✓

4.8 How long they will be retained?

Till 2016 in a password protected system

4.9 How they will eventually be disposed of?

The files; both soft and hard copies will be deleted and destroyed.

4.10 How do you intend for the results of the research to be used?

They basic use is to help me produce something productive to be awarded a PhD. However my finding may have implications for policy formulation and social work practices which may involve recommendations on improving institutional care for older persons in Goa.

4.11 Will feedback of findings be given to participants? YES✓

If YES, how and when will this feedback be provided?

The preliminary transcripts or feedback pertaining to participant observation and semi-structured

interviews will be shared with all research participants concerned. In a similar fashion, the feedback of the research would be shared with those who lack capacity in any form including reading, in simple and understandable language.

SECTION 6: PARTICIPANT INFORMATION AND CONSENT

5.1 Will written consent be obtained from participants? YES✓

If YES, attach a copy of the information sheet and consent forms.

Find attached.

In some contexts of ethnographic research, written consent may not be obtainable or may not be meaningful.

If written consent will not be obtained, please explain why circumstances make obtaining consent problematic.

Administrative consent may be deemed sufficient:

a) for studies where the data collection involves aggregated (not individual) statistical information and where the collection of data presents:

   (i) no invasion of privacy;

   (ii) no potential social or emotional risks:

b) for studies which focus on the development and evaluation of curriculum materials, resources, guidelines, test items, or programme evaluations rather than the study, observation, and evaluation of individuals.

5.2 Will administrative consent be obtained in lieu of participants' consent? YES✓

If YES, explain why individual consent is not considered necessary.

Individual consent is of prime importance for the study and will be given priority in all situations. However the researcher is sceptical about receiving informed consent from residents who lack cognitive capacity like in extreme conditions of dementia and at this stage the Next of Kin will be considered, however in their absence administrative consent will be considered necessary to help the research move on.

5.3 In the case of minors participating in the research on an individual basis, will the consent or assent of parents be obtained? NA

If YES, explain how this consent or assent will be obtained.

If NO, give reasons.

5.4 Will the consent or assent (at least verbal) of minors participating in the research on an individual basis be obtained? N A

If YES, explain how this consent or assent will be obtained.

If NO, give reasons.

5.5 In the case of participants whose first language is not English, will arrangements be made to ensure informed consent?

YES✓

If YES, what arrangements will be made?

The research will make arrangements to have the consent form translated in the local language of the resident.

If NO, give reasons.

5.6 In the case of participants with special educational needs will arrangements be made to ensure informed consent? NA

If YES, what arrangements will be made?

If NO, give reasons.

SECTION 6: CONFLICT OF INTEREST

The University has a draft 'Policy on the Conflict of Interest' (copies available from the Research Support Office). Regarding research the draft states that a conflict of interest would arise in cases where an employee of the University might be

" compromising research objectivity or independence in return for

financial or non-financial benefit for him/herself or for a relative or friend."

The draft policy also states that the responsibility for avoiding a conflict of interest, in the first instance, lies with the individual, but that potential conflicts of interest should always be disclosed, normally to the line manager or Head of Department. Failure to disclose a conflict of interest or to cease involvement until the conflict has been resolved may result in disciplinary action and in serious cases could result in dismissal.

6.1 Does your research involve a conflict of interest as outlined above NO ✓

If YES, give details.

Appendix 7: Application form for admission to a Government home

Form I

AFFIDAVIT CUM DECLARATION

I, the undersigned Shri/Smt/Kum,.....
Son/daughter/widow/widower of.....aged
.....Year's..... married/unmarried, resident of .....
.....Indian
National, do hereby solemnly affirm. declare and state on oath as under:-

1. That I am destitute / deserted by my family members or relative/ orphan/ aged/crippled/disable and I am not looked after by any of my family member/s or relatives.

2. That I desire protection and help from the Department of Public Assistance (Provedoria) in these circumstances, and I agree to abide by the rules and the regulations of the Department of Public Assistance (Provedoria).

3. That I agree to abide Instructions issued by the Incharge/Steward/ Stewardess and any other authority of the institution, in the interest of the smooth functioning of the Institution.

4. That I shall not leave the Institution without recording my movement in the register maintained for the purpose and shall obtain the permission of the Incharge for doing so.

5. That I shall be regular and punctual in attending each and every activity including meal times.

6. I shall observe instructions regarding use of the property of the home given for personal use.

7. That I shall not indulge in gambling or drinking or any other vices during my stay in the Home of Provedoria.

8. That I am physically and mentally fit an not suffering from any contagious disease and can move about freely.

9. I do not have any cash with me in hand or in the Bank.

OR

I hereby declare that I have at present with me

Rs.....In cash and Rs..... in my Banking

Account No..... In Bank.....

10. I hereby declare that I do not have any gold ornaments with me

OR

I hereby declare that I have with me the following Gold ornaments.

(a).....grams (b) .....grams

(c) .....grams (d) .....grams

11. That I have immovable properties i.e. ..... bearing Reg.No. .....known as..... and bearing Survey No.....

12. I hereby declare that I have handed over above said cash Rs..... (Rupees.....only) And the above said Gold Ornament to the /Incharge/Steward/ Stewardess at the time of my admission and I do hereby agree and declare that incase of demise while I am under the care of Provedoria, the above said some of Rs. ..... and Gold Ornaments as well as those ornament on my person consisting of. ....the Immovable property/properties mentioned above a also the rest of my belonging shall belong and will be the property of D.P.A. (Provedoria) as I do not desire that it should passed on to any of my relative/family members after my death.

13. That I am receiving Pension under the D.S.S. Scheme and agree to deposit a sum of Rs.500/- being 50% of my dole to the D.P.A. (Provedoria) towards token of maintenance charges.

14. I agree that incase I do not observe the above conditions from Sr. Nos. 2 to 7. I may be discharged from D.P.A. (Provedoria).

I say that the contents above name are true to my own knowledge.

Solemnly affirmed at ..... Goa, this .....day of 20.....

Executant

INSTITUTE OF PUBLIC ASSISTANCE
PROVEDORIA DA ASSISTENCIA PUBLICA
PANAJI - GOA

APPLICATION FOR ASSISTANCE

To,
The Director
Institute of Public Assistance
Panaji - Goa

Sub: Request for :

1. Admission
2. Financial assistance for :

a) Purchase of medicines
b) Purchase of spectacles
c) Purchase of Artificial limb / callipers
d) Celebrating marriage of a girl
e) Being a Stranded visitor
f) Burial or cremation of deceased family member

(Tick whichever is applicable)

Dear Sir,

I I am in need of assistance for the following reasons.

1. _____
2. _____
3. _____

I information as would facilitate decision, on my request is furnished below :

Yours faithfully,

(Signature or left hand thumb impression of the applicant)

1. Full name in capital letters : _____
2. Address in full including _____
   house No. _____
3. Age : _____

III Members of the family living with the applicant.

Sr. No.	Name	Age	Relationship with the applicant	Occupation	Income per month
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					

IV. Members of the family not living with the applicant

1) _____

2) _____

3) _____

4) _____

(Please score out which is not applicble)

V Herebelow give a brief story of the case indicating special reasons if any requesting assistance.

_____

_____

_____

_____

VI Income of the applicants family from all sources including that earned by the other members living with the applicant.

Sources	**Amount earned yearly**
Land produced	_____
House rent	_____
Service / Labour	_____
Other work	_____
The size of land owned	_____
Cultivated ur on rent	_____
Land owned	_____
Land rented	_____

Income of land terms of produce

Paddy_____ owned land _____ rented land

_____ coconuts _____. _____ other produce

VII Are any members of the applicant's family in position to work ?
Yes / No.

If Yes, than say what kind of work he/she could do to earn a living for the family.

Sr. No.	Name	Age	Kind of work he/she could do
1)			
2)			
3)			
4)			
5)			
6)			

VIII State present monthly income of the family, from all sources which helps the applicant's family, to maintain itself Rs. _____ _____.

State approximate minimum monthly expenditure Rs. _____

IX Did any member of the applicant's family receive / received any assistance from the Institute of Public Assistance or other public agencies.

Yes No.

If Yes, please give the following information

Sr. No.	Name and address of the agency	Amount received for the month	when
1)			
2)			
3)			

Residential Certificate for 15 yrs.

Medical Certificate

Marriage registration certificate

Extension officer certificate

Income certificate Enclosed / not enclosed

Affidavit

Place :

Date _____

Signature / thumb impression of the applicant

Appendix 8: Profile of respondents

Religious Home									
Pseudonym	**Educational Level**	**Gender**	**Age**	**Tenure**	**Payment**	**Marital Status**	**Family**	**Religion**	**Job**
Residents									
Leena	No formal education	F	75	25 Years	500	single	none	C	Unemployed
Felix	Graduate	M	80	10 Years	3000	single	brother	C	Administrator
Violet	Graduate	F	80	7 Years	3000	married	2 daughters	C	Teacher
Julian	SSC + Art Diploma	M	78	10 Years	Free	married	1 son, wife	C	Daily wages
Marcus	SSC	M	70	5 Years	3000	single	brother	C	Daily wages
Fatima	No formal education	F	70	10 Years	3000	single	none	C	Daily wages
Mary	SSC	F	75	10 Years	3000	married	5 sons	C	Unemployed
Reggie	SSC	M	68	6 Years	3000	single	sister	C	Daily wages
Staff									
Pramila	No formal education	F	25	8 Years	2000			C	
Lata	No formal education	F	20	4 Years	2000			C	
Lucy	No formal education	F	20	4 Years	2000			C	
Raju	No formal education	M	24	4 Years	3000			C	
Manager									
Jeanette	Graduate + Nursing Diploma	F	50	5 Years	service			C	

Government Home									
Pseudonym	**Educational level**	**Gender**	**Age**	**Tenure**	**Payment**	**Marital status**	**Family**	**Religion**	**Job**
Residents									
Alice	No formal education	F	65	5 years	500	S	daughter	C	daily wages
Carmen	High School	F	70	7 years	500	W	children	C	daily wages
Laxmi	No formal education	F	65	5 years	Free	D	none	H	daily wages
Milena	High School	F	70	10 years	Free	D	children	C	daily wages
Gajendra	Handicraft	M	75	10 years	Free	S	none	H	daily wages
Valerian	No formal education	M	70	10 years	Free	S	none	C	unemployed
Raja	No formal education	M	70	8 years	Free	S	brother	H	daily wages
Lactacio	No formal education	M	75	10 years	500	S	sister	C	daily wages
Staff									
Kareena	No formal education	F	30	7 years	4000			H	
Savita	No formal education	F	40	5 years	4000			H	
Gabriel	No formal education	M	54	20 years	5000			C	
Prabakar	No formal education	M	45	10 years	5000			H	
Manager									
Isabel	12^{th}	F	50		15000			C	
Rahul	High School	M	37		12000			H	

Private Home									
Pseudonym	**Educational level**	**Gender**	**Age**	**Tenure**	**Payment**	**Marital status**	**Family**	**Religion**	**Job**
Residents									
Arjun	Post Graduate	M	75	10 years	3000	w	3 daughters	H	teacher
Sunil	Graduate	M	80	8 years	Free	s	none	H	accountant
Lawry	Post Graduate	M	80	7 years	3000	w	2 daughters	C	lawyer
Rajan	Post Graduate	M	75	5 years	3000	w	1 son, 1 daughter	H	sales manager
Sarita	Graduate	F	75	6 years	3000	s	none	H	unemployed
Sheetal	Graduate	F	70	10 years	3000	m	2 sons, husband	H	unemployed
Rekha	Graduate	F	70	8 years	3000	w	7 sons	H	teacher
Madhuri	SSC	F	75	6 years	3000	w	2 sons	H	ayurvedic doctor
Staff									
Deepa	Graduate + Nursing diploma	F	37	10 years	10000			H	
Vishanti	SSC	F	30	7 years	5000			H	
Suraj	No formal education	M	45	25 years	5000			H	
Shyam	SSC	M	40	8 years	5000			H	
Manager									
Karuna	Post Graduate	F	55	10 years	25000			H	